Medical Pluralism among the Hyolmos:

An Ethnographic Study from Mid-Hill of Central Nepal

A Dissertation

Submitted to the Dean's office, Faculty of Humanities and Social Sciences,

Tribhuvan University

In Fulfillment of the Requirements for the Degree of

DOCTOR OF PHILOSOPHY

In

Anthropology

By

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April, 2016

LETTER OF RECOMMENDATION

We certify that this dissertation entitled **"Medical Pluralism among the Hyolmos: An Ethnographic Study from Mid-Hill of Central Nepal"** has been prepared by **Ram Hari Dhakal** under our guidance and supervision in fulfillment of the requirements for the Degree of Doctor of Philosophy in Anthropology. We, hereby, recommend this dissertation for the final approval by the Research Committee of the Faculty of Humanities and Social Sciences, Tribhuvan University

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APPROVAL LETTER

This dissertation entitled **"Medical Pluralism among the Hyolmos: An Ethnographic Study from Mid-Hill of Central Nepal"** has been submitted by Mr. **Ram Hari Dhakal** for final examination by the Research Committee of the Faculty of Humanities and Social Sciences, Tribhuvan University in fulfillment of the requirements for the Degree of **Doctor of Philosophy** in **Anthropology**. I, hereby, certify that the Research Committee of the Faculty has found this dissertation satisfactory in scope and quality and it has, therefore, been accepted for the degree of Doctor of Philosophy in Anthropology.

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Prof. Chinta Mani Pokharel, Ph.D.

Dean and Chairman

Research Committee

April 28, 2016

DECLARATION

I hereby declare that this Ph. D. dissertation entitled "**Medical Pluralism among the Hyolmos: An Ethnographic Study from Mid-Hill of Central Nepal"** submitted to the office of the Dean, Faculty of Humanities and Social Sciences, Tribhuvan University is an entirely original work presented under the supervision of my supervisor, Prof. Dr. Laya Prasad Uprety and co-supervisor Prof. Dr. Binod Pokharel. I have made due acknowledgements to all ideas and information borrowed from different sources in the course of writing this dissertation. The results presented in this dissertation have not been presented or submitted anywhere else for the award of any degree or for any other reason. No part of the content of this dissertation has ever been published in any form before. I shall be solely responsible if any evidence is found against my dissertation.

Ram Hari Dhakal

April 28, 2016

ACKNOWLEDGEMENTS

This dissertation is an outcome of my four years' engagement as a Ph.D. candidate in Anthropology since February 2012. This research would not have been possible without the support of many personalities. First of all, I express my sincere gratitude to Prof. Dr. Laya Prasad Uprety as my supervisor who always inspired me in every step and encouraged me through his constructive suggestions and valuable academic inputs. I am thankful to Prof. Dr. Binod Pokharel, my co-supervisor, who supported me by providing constructive comments and suggestions.

I would like to thank Dr. Suresh Dhakal who always inspired and encouraged me for further study. I am further thankful to him for evaluating and providing inputs on the review of literature. I also thank Dr. Mukta Singh Lama for giving constructive comments in my literature review. I owe a huge debt to Prof. Dr. Om Gurung, the Head of Sociology/ Anthropology Department, for his great support on my study. He directed me by evaluating my proposal and seminar paper. I had the privilege of guidance from other professors to whom I would like to thank from the core of my heart as the dissertation progressed. I am very grateful to Prof. Dr. Ram Bahadur Chhetri as the internal evaluator and Prof. Dr. Dilli Ram Dahal and Prof. Dr. Padam Lal Devkota as the expert for their critical comments, invaluable insight and constructive suggestions. I would like to thank the Dean's Office, Faculty of Humanities and Social Sciences for providing me with the opportunity to enroll in Ph.D. and providing the necessary administrative support in each step of research.

My special thanks go to Dr. Bishnu Khanal, Mr. Binod Dhakal, Mr. Aita B.K., Mr. Kedar Prasad Simkhada and Mrs. Shanti Aryal for their regular support and encouragements. This study would have been incomplete without their support. For language correction and editing, I would like to acknowledge Dr. Binod Luitel (Associate professor, English Education, Tribhuvan University) and Mr. Mahesh Maharjan for their support by going through my work and furnishing the language from top to bottom. I would like to thank Mrs. Mamitra Ale for supporting me in typing this text. My sincere thanks go to Mr. Noor Jung Shah for his support for checking APA format. I am also

thankful to University Grants Commission for the financial support to buy the necessary literary texts and travel allowance for field work.

A very special acknowledgement goes to my parents and family members who always encouraged and supported me for further study up to Ph.D. level. I am proud of my parents Bhoj Raj and Chini Maiya. I must remember my life mate Goma who probably would be the happiest person listening to my progress. I also have to thank my children Aakriti, Aarati and Aadarsh who supported me from their level to complete my dissertation innocently without knowing the value of Ph. D. I am very thankful to all the family members for their encouragements including my brother Ramchandra who supported during my fieldwork.

Last but not the least; I am very thankful to those Hyolmos and non-Hyolmo respondents and key informants of Helambu for providing me the necessary information. Without their support, I could not imagine the research and this research would have been obviously incomplete. Among the key informants, I must remember Mr. Purna Bahadur Gautam, Mr. Kamal Basnet, Mr. Mani Prasad Adhikari, Mr. Devraj Dahal, Mr. Kami Lama and Mr. Pema Tasi Hyolmo who remarkably supported me during the fieldwork. The non-Hyolmo informants supported me for rapport building with the villagers in my initial entry in the field. I thank all the teachers of Melamchi Ghyang School, the members of mothers' group, forest users' group and different healers for sharing the valuable information needed for my doctoral research.

Ram Hari Dhakal

ABSTRACT

Every society has distinct ways to understand and get solutions to health problems. It differs on tools, procedures, time, sources and service providers which tend the society towards pluralistic paradigm in medical practices. The main objective of this research is to explore existing medical practices and their reason of choice along with the people's perception on illnesses and healers. This research also explores the changes on medical choice and its causes.

Explanatory model as a theory was used to know the peoples' perception on illness, its causes, effects, and the ways to be better based on eight qualitative open ended questions and case study to get the responses on disease, illness, pain, and suffering and to identify the factors of health and healing as overlapping sectors in healthcare tradition.

The universe of this study is the Hyolmos of Melamchi Ghyang, Helambu. This study is based on primary data which were gathered through census, key informant interview, focus group discussion, case study and observation. The collected data were edited, coded, classified and tabulated for comparison, analysis and generalization. The data texts gathered from interview were transcribed to derive themes from the collected data set. The quantitative data gathered from census were analyzed using simple statistical tools which clarified socio-economic, cultural, political and educational background of the medical choices. Qualitative data were analyzed using the thematic classification system. Adoption of plural medical practices is taken as dependent variables and factors in influencing the changes on medical practices are taken as independent variables in this study and these two variables are analyzed on the basis of peoples' perception towards different medical practices.

People in Nepal have utilized several medical and healing practices at a time based on availability and access to get well soon and have often mixed the use of traditional and western practices together. Medical pluralism is the co-existence of multiple medical systems, which is also prevalent in Hyolmo community. They utilize popular medical practices which consist of the health care conducted by non-specialized persons like their families, relatives, social networks and communities; it includes diet, herbs, exercise, sanitation, meditation, self-medication and various ethno-medical practices. The next is folk/traditional medical practice which is identified as the folk form

of healing done by non-professional, non-bureaucratic specialists who are trained informally. It consists of *kulpuja (Kangsu),* Lamaism, *Dhami / Jhankris, Aamchi, bhakal*, mascot etc. and the professional medical sector involves the specialized knowledge-based education imparted through formal education, such as allopathic practice of health post and hospital. The reasons to use more than one health-seeking strategy were: easy availability of service provides, cheaper in cost, culturally accepted, getting well sooner and belief on multiple providers.

Perception of people plays important role to choose any health service. The perception is made on the basis of efficacy of health care services and nature of illness. Self-medication is the first and health post is the second choice of priority for local villagers and their final destination of treatment is hospital, but initially many of them go to *Jhankris*. People have positive perception towards health post, Lamaism, self-medication and herbal practices despite the inadequacy of these healing practices. The new generations are not much positive towards *Jhankris* but people with traditional thinking believe in them.

Hyolmos think that there are natural causes (environment, climate, food habits) and supernatural causes (spirit, evil power, and god) of illnesses. The causes of diseases and illnesses are carelessness on health behavior, mental tension, low immunity power, mal-adjustment to environment and evil spirits, and the common illnesses are cough, cold, uric acid for old, headache, pneumonia in children, fever, cold diarrhea, body pain and wounds. Nowadays, patients of gastritis, blood pressure, TB and diabetic mellitus are increasing.

Hyolmos' medical practices, priority, choice, procedure and belief system have been found changed rapidly for the last three to four decades. It is due to various factors. Education and awareness is the major factor which has brought changes in it. The other responsible factors to bring changes are transportation, communication, access to health post, tourism, foreign employment, contact with lowland people and city dwellers, intermarriage practice, establishment of national park, formation of forest user group and political awareness.

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ABBREVIATIONS & ACCRONYMS

AD	Anno Domini (the year of the Jesus Christ)
AIDS	Acquired Immune Deficiency Syndrome
APA	American Psychological Association
AYUSH	Ayurveda, Yoga, Unani, Siddha and Homeopathy
BP	Blood Pressure
BS	Bikram Sambat
C	Celsius
CAN	Community Action Nepal
CBS	Central Bureau of Statistics
EM	Explanatory Model
EMIC	Explanatory Model Interview Categories
FGD	Focus Group Discussion
FM	Frequency Modulation
HBM	Health Behavior Model
HH	Household
HIV	Human Immune Deficiency Virus
HP	Health Post
IPQ	Illness Perception Questionnaire
JTA	Junior Technical Assistant
Km	Kilometer
LP	Liquefied Petroleum
MBBS	Medical Bachelor and Bachelor in Surgery
MoH	Ministry of Health
ODF	Open Defecation Free
Ph D	Doctor of Philosophy
RMP	Registered Medical Practitioners
SEIM	Short Explanatory Interview Model
SLC	School Leaving Certificate
Sq Km	Square Kilometer

TB	Tuberculosis
TV	Television
UK	United Kingdom
UNDP	United Nations Development Program
US	United States
VDC	Village Development Committee
WHO	World Health Organization

CHAPTER I:
INTRODUCTION

Background

Medical pluralism is the existence of different medical practices that are historically prevalent in a society in which there are several systems grounded in different principles or based on different worldviews. It is the adoption of more than one medical system or the multiple uses of medicine, methods, procedure, healers, etc., which may be noticed in people's conception of disease and illness. It determines the medical dimensions. It encourages pragmatic willingness to examine the personal and cultural meaning associated with complementary and alternative medicine.

Medical pluralism is a theoretical model that represents most of the world's medical systems. It is one of the most prominent theories in anthropology (Burghart, 1996; Durkin-Longley and Maureen, 1984; Good, 1994; Kleinman, 1980; Pigg, 1995, 1996). Medical pluralism includes all medical systems, including those within pluralism (Rashid 2008; Stoner 1986; Subedi & Subedi 1992). It suggests that most cultures are host to several medical systems operating and existing in tandem. This contrasts with earlier theories that suggest that only one medical system is truly operating in any given context (Good 1994). Medical systems comprise of ideas, values, and behaviors that are created by individuals within a culture and are institutionalized into real practice. Within a medically pluralistic context, this would mean that the concepts in different medical systems are more readily intertwined; the people operating within these systems create their own medical concepts and these concepts are frequently a unique mix of different medical systems inherent within their cultural context (Burghart 1996; Pigg 1995; Rashid 2008).

The meaning of medical pluralism, a sub-field of medical anthropology, can be understood from different aspects such as people's conception of disease and illness, their resort to medical practices belonging to different systems, and their responses to other medical dimensions. For instance, inhabitants can categorize their illnesses as personalistic versus naturalistic (Foster & Anderson 1978) and natural versus supernatural (Devkota 1984). People resort to faith healers like *Jhankris* for supernatural causes of illness and to allopathic healers like doctor for natural causes of illnesses.

People think that one can heal more effectively in a sector of health problem whereas the next can be more effective for the other.

Scholars have attempted to explore medical pluralism in different parts of Nepal and in Nepali culture**.** Burghart (1996) explored communication and miscommunication between Western-trained Nepali medical providers and their rural patients. Gellner (1994) focused on shamans in Kathmandu, exploring both the ideological and social context of this medical system within the city. Kohrt and Harper (2008) conducted a multidisciplinary study concerning psychiatry and stigmatization of mental illness within Nepal and compared the results they found with the way mental disease is understood in Western medicine.

Nepali medical practices have been influenced by many different sources throughout the history. Most of the modern inhabitants of Nepal trace their ancestry to various waves of migrants who brought with them, from their origins, many beliefs and practices regarding illness (Beine 2003). The original Bodic-speaking people of pre-fourth century Mongolian origin brought with them central Asian shamanic practices that are still evident in some of the healing practices observed among shamans today (Watters 1975, as cited in Beine 2003; Streefland 1985). Khas tribes who started settling in Nepal around 2000 BC brought with them ancient Ayurvedic traditions from India that are still widely practiced today (Dhungel 1994; Streefland 1985). Wave of Muslims brought with them Greeco-Arabic medical beliefs and practices that are evident in modern-day homeopathic medical practices (Blustain 1976).

Later wave of migrants from Tibet brought with them Tantric Buddhist ideas about healing that are still popular today (Durkin 1994; Streefland 1985). Recently, the allopathic ideas of Western medicine have been introduced and well accepted (Acharya 1994; Dhungel 1994; Durkin-Laungley & Maureen 1984; Pigg 1995; Streefland 1985). This signifies that the major characteristic feature of Nepali medical system is pluralistic in nature.

Nepal is a multicultural, multiethnic, multiracial, and multi-religious country. As there are diversities in many aspects including geography, it is no surprise that there are various methods of dealing with illnesses. The various groups have their own concepts about disease and illness. Medical pluralism can also be observed in these differences.

Nepal is a country having hundreds of castes and ethnic groups. Among them, one of the ethnic groups is Hyolmo, who reside in the high hill region, primarily concentrated in the Sindhupalchok district of central Nepal.

Hyolmos[1] are Buddhist people whose ancestors migrated as refugees during the 13th to 15th centuries from the Kyerong region of Tibet to the forested foothills of the Hyolmo region (Clark 1980b). Hyolmos had migrated from Tibet to Nepal in order to be free from religious persecution. A Mongol king had attempted to convert Hyolmo to his sect of Buddhism, the people fled to the Khumbu region and later moved further into the Helambu region. History shows that Hyolmo comprises of people from different communities of Nepal and Tibet. Hyolmos were recognized as Lama and Sherpa in the past. Later they claimed themselves as Hyolmo. The term "Sherpa" means "people from the east" in the Tibetan language.

Hyolmo region is almost directly to north of the Kathmandu Valley, just inside Nepal but bordering to Tibet. The region is also called Yolmo (as mentioned by the Buddha, Guru Rimpoche, Marpa, Milarepa etc.) or Helambu (by most of the Nepalese). Desjarlais (2003) states the term Hyolmo has widely been used by Buddhists and Bodhisattavas from centuries ago and is still used by great Tibetan masters and great practitioners. Helambu is the main homeland of Hyolmos. The word "Helambu" is derived from Hyolmo. It is located in the high hill of Sindhupalchok, about 100 kilometers northeast of Kathmandu. Hyolmo region encompasses the northwest of Sindhupalchok, the northeast part of Nuwakot, and southeast part of Rasuwa district. Desjarlais (2003) argues that although most of the Hyolmo people and others call the name of the region as Helambu, it is believed to be a nickname for Hyolmo given by mistake or due to the lack of knowledge of the unlearned Hyolmo persons.

Hyolmos are the central mountain ethnic group having indigenous skills of carpentry, bamboo production, Thanka painting and woolen production (Rapcha 2014). Now they are involved in various modern works besides the use of their indigenous

[1] Desjarlais (1992, 2003) and Clark (1980a, 1980b) used the terms "Yolmo" and "Hyolmo" that are also commonly found in Nepali government documents. Both the terms represent the same ethnic group. Hyolmos themselves also claim that the correct term is Hyolmo, thus I have also used the term in this research.

skills. Animal rearing was their main occupation along with agriculture in the past. Long ago, Yolmo people herded yak, and the main source of income was based on herding (Desjarlais 2003). Now they also work in different cities of India and other countries.

Hyolmo people have close cultural and linguistic affinity with the inhabitants of the Kyerong and Rongsyar areas of Tibet. The language of the Hyolmos is very similar to that of Tibetans. It consists largely of classical Tibetan terminology as used in religious scripts called *Pechas*. They claim themselves as *Hyolmo wa* in their language, which means "Hyolmo people." They can still communicate in a simple form of Tibetan (Desjarlais 2003). Today they speak this language along with Nepali. It is spoken by most of the central Tibetans, but the difference is only in the way of pronouncing words. Desjarlais states that the Yolmo language is mostly understood by Tibetans from central Tibet (Lhasa) and some other parts of Tibet. One can find most of the Yolmo words in the Tibetan dictionary. Linguists have identified this unwritten language as Kagate, a Tibetan dialect that acquired its name because it was first recorded as spoken among a group of Kagate or "papermakers" in eastern Nepal.

Almost all (99.78 percent) the Hyolmos are Buddhists, only 0.22 percent are Hindus. The total population of Hyolmo is about 19,000. Among them, 17,000 are in the Bagmati Zone; 2,300 in the Janakpur Zone; and very few are in other areas (CBS 2011). Being Buddhists, every Hyolmo has a decorated corner of the house set aside for their gods. High places are often areas of worship, where flags with prayers written on them are hung with the hope that some god may hear their prayers.

Hyolmos are indigenous people rich in language, culture and tradition that they have been practicing from time immemorial. This gives them a unique identity; and Helambu, their homeland, is considered as a sacred place situated over a beautiful terrain in the lap of mountain to the north-east of the capital city, Kathmandu. It is situated just at the basement of Holy Mountain in the north of monastery called Ama Jyomo Yangri.

Every society develops its own perception and understanding of different healers and the medical tradition to deal with fundamental health concerns. Medical practices differ not only from society to society; the practices differ from culture to culture. Even in a single society, different ethnic groups may have different medical practices. Hyolmos also have developed different healing and medical practices, but their plural medical

practices have still not been assessed for in-depth study. The purpose of the current study is to investigate the different healing and medical traditions, their conditions, peoples' choices about healing, healing procedures, and the dynamism on medical choices.

Statement of the Research Problem

Medical pluralism is the multi-medical practices of different cultural groups. It may mean co-existence of multiple traditions of medicine, including what are called "folk sectors" (Kleinman 1980). It presents multiple choices of therapeutic traditions to the individual (Durkin-Longley & Maureen 1984). Since the 1970s, anthropologists have focused on medical pluralism such as Ayurveda, Unani, folk medicine, biomedicine in India (Leslie 1980); religious healing and biomedicine in China and Japan (Kleinman 1980; Leslie 1980; Ohnuki-Tierney 1980); chiropractic, osteopathy, naturopathy, spiritual healing, biomedicine in the USA (McGuire 1983); *Kur*, homeopathy, herbal medicine, reflexology in Europe (Johannessen 1994; Sharma 1992); and self-medication, indigenous medical practices, Ayurvedic, homeopathic, and allopathic medical traditions in Nepal (Subedi, 2001).

Medical practice differs from society to society, by geographical location and by cultural groups. Subedi (2001) states that the medical practices include both the cognitive and social systems of healing and treatment traditions. Cognitive tradition relates to a wide range of medical concepts, values, attitudes and beliefs that serve as guidelines for health action and practices. Thus, people have different theories of causality of an illness among various medical traditions. The social system dimension refers to the different economic, institutional and organizational aspects of treatment and health care delivery system. In looking at health care pluralism, it is important to examine both the cognitive and social aspects of the types of health care available to the individual patient.

Culture plays a significant role in a person's understanding and interpretation of illness (Helman 1995). Every society has developed its own perception about health and illness. People think about the cause of health problem and its effect differently. They follow different practices even for the same problem. They also categorize illnesses on the basis of the nature of their seriousness, and they adopt the course of treatment accordingly. This research focuses on the issues concerning why and how people adopt

different types of healing practices simultaneously and what kind of socio-cultural variables affect their medical choices.

As a sub-field of anthropology, medical anthropology has emerged as a holistic approach to analyze the health problems followed by people. Looking at the different medical practices and peoples' choices, various questions emerged in my mind about the perception of people on different illnesses, causes of problem, its effects on body, degree of severity, course of medicine expected for recovery and their fear about sickness. To explore the answer to these qualitative questions, my journey to Ph.D. research began basically to know why plural medical practices exist at a place, who goes where for the treatment and why, and to explore the causes and consequences of the changes in traditional indigenous practices at micro level in addition to these qualitative issues.

Another question related to health-seeking behavior is: What are the changes in peoples' medical practices, and what are the contributing factors of these changes? These issues related to health are examined among Hyolmos, an ethnic group of mid-hill of central Nepal.

This study has attempted to investigate why certain health seekers who belong to the same village and have the same tradition go to different places to seek treatment for the same disease. Hyolmos have particular traditional and ethno-medical practices but it is influenced by various factors.

The main research question of this research is: What are the medical and healing practices of Hyolmos?

Subsidiary questions that follow from the main question to fulfill the objectives of the study are as follows:

i. Why do Hyolmos follow more than one health-seeking strategy?

ii. What causes do they attribute to their illnesses?

iii. How do they determine the health-seeking priorities?

iv. What are peoples' perceptions on each of the healing beliefs and practices?

v. What do the healers think of themselves and their healing system?

vi. What factors significantly influence their health-seeking behavior?

vii. What changes do people observe in medical practices?

viii. What are the factors that are perpetuating or/and changing the health care practices in Helambu?

Objectives of the Study

The general objective of the study is to understand the medical choices of Hyolmo people. The specific objectives of the study are as follows:

i. To explore the existing medical practices of the Hyolmos of Helambu;
ii. To investigate the peoples' perceptions in the efficacy of medical beliefs and practices, and
iii. To analyze the changes on medical choices and the factors contributing to the change.

Theoretical Perspectives

Anthropologists use different methods and theories when explaining health and sickness behaviors in different cultures. The earliest anthropologists while explaining medical beliefs and practices used conceptual systems which were originally meant for phenomenological domain. The initial work of defining medical anthropology was made possible by the existence of ethnographic studies on rites and religion (Evans-Pritchard 1937; Turner 1967). These studies tried to explain medical events in structurally simple, kinship-based societies where the people's attention was concentrated on the social and symbolic condition of sickness. Other approaches include culture and personality school in ethnology; physical anthropology; and the simultaneous action of an international movement for public health (Johnson & Sargent 1990).

Ethno-medicine. Ethno-medical studies of health and healing are the major province of medical anthropology. It is a sub-division of medical anthropology, the lineal descendent of the early interest of anthropologists in the medical institutions of non-Western people. Anthropologists focus on the field of primitive medicine in a cultural complex that includes various materials and non-material cultures, i.e., either medicine or beliefs; and next is medical practice as a part of social structure, i.e., the network of relations between groups or persons. Anthropologists' concern is to deal about different indigenous medicines which are practiced by tribal people.

Ethno-medicine is the folk ideas and practices concerning the care and treatment of illness available within particular cultures that is outside the framework of professionalized, regulated scientific medicine. Ethno-medical analysis focuses on cultural systems of healing and the cognitive parameters of illness. This approach often attempts to discover the insiders' viewpoints in describing and analyzing health and systems of healing. Treatment in this kind of medical practice commonly involves empirically-based natural remedies, frequently from plants, and healing rituals with supernatural elements.

The subject matter of interest in medical anthropology includes ethno-medicine; explanation of illness and disease; causes of illness; the evaluation of health, illness and cure from both an *emic* and *etic* point of view; *naturalistic* and *personalistic* explanation (Foster & Anderson 1978), natural and supernatural explanation (Devkota 1984), evil eye, magic and sorcery; biocultural and political study of health ecology; types of medical systems; development of systems of medical knowledge and health care, and patient-practitioner relationships; political economic studies of health ideologies and integrating alternative medical systems in culturally diverse environments.

Ethno-medicine is a branch of medical anthropology which includes those beliefs 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 (Gartoula 1998; Hughes 1968). It is the traditional non-western medical system. It is a traditional subject matter of anthropology about the medical knowledge of tribal, peasant and other pre-industrial people. It is the study of ethnography of health and healing behavior in various societies. It also refers to the study of traditional medical practices which encompasses methods of diagnosis and treatment. Ethnomedical studies are conducted to evaluate the efficacy of traditional health care practices; the prevalence of illnesses and the distribution of knowledge about illness attributes; the negotiations and instantiation of illness identities.

Various kinds of plants, roots, leaves, etc. are applied in treatment procedure with the help of local knowledge. In addition to medicine, spiritual and supernatural powers are also practiced to cure diseases. It is more prevalent in traditional society. Along with

the touch with modern world, ethno-medical practices are decreasing, which is one of the concerns of this research.

The ethno-medical perspective focuses on health beliefs and practices, cultural values, and social roles. Originally limited to the study of primitive or folk medicine, ethno-medicine has come to mean the health maintenance system of any society. It also encompasses knowledge and values of specialists and lay people; the roles of healers, patients or clients, and family members; the implementation techniques, legal and economic aspects of health practices; and symbolic and interpersonal components of the experience of illness. Pluralistic societies often encompass several ethno-medical systems.

Humoral medicine, derived from ancient Greek medicine, coexists with systems in Latin America, the Middle East, Malaysia, Indonesia, and the Philippines. Ayurvedic medicine in India and Chinese traditional medicine hold humoral elements with the elements of other systems (McElroy 1996). The various ethno-medical practices have been developed by various caste and creeds in Nepal too.

A key concept in ethno-medicine is "explanatory model," introduced by Arthur Kleinman (1978, 1980). Explanatory models (EMs) are notions about the causes of illness, diagnosis, and treatment options. In a clinical encounter, the EMs held by practitioners, patients, and families often differ. The ensuing communication and negotiation of decisions for managing illness leads to the cultural 'construction' of illness. To the extent that disparity among EMs continues because of cultural, ethnic or class differences, communication remains problematic (McElroy 1996).

The disease-illness distinction is important conceptually in the study of ethno-medicine. Disease, defined clinically as deviation from medical norms, is considered to be a Western bio-medical category and not universal. Bio-medical terms such as 'hypertension' or 'diabetes' may not correspond to diagnostic categories of a given ethno-medical system. Illness, in contrast, is the experience of impairment or distress, as culturally defined and constructed. Cause of the illness may also be located in social and spiritual realms, so that ethno-medical aetiology may include sorcery, soul loss, and spirit intrusion (McElroy 1996). In this sense, ethno-medicine is broader than the western bio-medical category which also incorporates the causes of illness by supernatural power.

Attention has been given since the mid-1980s to integrating ethno-medicine and ethnoecology, as in studies of indigenous people's knowledge of medicinal plants. There is also strong interest in clinical applications of ethnomedical treatments (McElroy 1996). The western medical practices came in practice in Nepal recently. Even though it is still limited in urban areas, many of the rural people are still deprived from the service of this category. They have been depending on ethno-medical practices from time immemorial. As this study is based on rural people, it is essential to understand their ethno-medical practices which are also the major study area of medical anthropology.

Explanatory model. Kleinman (1980) developed a widely used model that recognizes three useful overlapping sectors in the health care traditions: the popular sector, the folk/traditional sector, and the professional sector. The popular sector consists of health care conducted by ill persons themselves, their families, relatives, social network and communities. It includes a wide variety of therapies such as special diets, herbs, exercise, rest, and baths or counter drugs. He mentions that in the popular health care sector a non-specialized person, usually in the household, uses a general body of knowledge to cure illness. He then identifies the folk sectors, in which healing is performed by non-professional and non-bureaucratic specialists who are trained informally or happen to have experience. This sector is considered an intermediate level between the popular sector and the professional health care sector. The professional sector involves highly specialized training and knowledge-based education, with a formal position of their practices, so social status may be high, depending on the society. In Western societies, professional sectors usually consist of one 'official' medical practice – namely a medical practice recognized by the state and having a somewhat privileged status in society (in anthropological research, this is usually referred to by the term 'biomedicine') and several other practices that are deemed 'alternative', 'complementary', 'unofficial', 'unorthodox,' etc.

An integrated framework of Explanatory Model is utilized in this dissertation. This model actively looks at the universal response to disease, illness, pain, and suffering, and it helps to identify the common factors of health and healing in various medical systems around the world. Inherent in this model is the idea that there can be a comparative understanding of folk and religious therapies alongside psychiatry and

biomedicine. Explanatory models provide a structure within which individuals sort out their health problems and understand illnesses, injuries and disabilities. This knowledge of prevention and cure of sickness is passed on from generation to generation. An explanatory model reveals how people make sense of their illness and their experiences of it. Explanatory model is often used to explain how people view their illness in terms of how it happens, what causes it, how it affects them, and what will make them feel better. It is a method used in both clinical settings, and qualitative research is a way to obtain individual explanations of a particular phenomenon (Kleinman 1978).

Explanatory model seeks to understand the basic elements that people associate with some illness. This model consists of the signs and symptoms by which a particular illness is distinguished, the assumed cause of illness, recommended treatments, how the illness is believed to work inside the body, and expected prognosis.

Arthur Kleinman's theoretical model of therapeutic process has been applied in my research which looks at the universal response to disease, illness, pain, and suffering and identifies the common factors of health and healing in various medical systems around the world. The model explains therapeutic process as an all-meaningful activity that mediates the procedure and outcome that develops the idea of comparative understanding of folk and religious therapies alongside psychiatry and biomedicine. It provides a structure within which individuals sort out their health problems and understand illnesses, injuries and disabilities. This knowledge of prevention and cure of sickness is passed on from generation to generation.

According to Arthur Kleinman, in every culture, illness, the response to it, individuals experiencing it and treating it, and the social institutions related to it are all systematically interconnected to the health care system, and like other cultural systems, it integrates the health-related components of society (1980). In most parts of the world today, no single system is solely used; instead, multiple modalities exist and are used parallelly. Whether these systems are regional in context or institutionalized by the larger society, it does not seem to matter; people have multiple options to choose from.

Researchers have refined the methodology of Kleinman’s model into a mixture of open-ended and direct questions that lets them quantify results (Weiss, Doongaji, Siddhartha, Wypic, Pathare, Bhatawdekar, Bhave, Sheth, & Fernandes 1992). These

include the Explanatory Model Interview Catalogue (EMIC), Short Explanatory Interview Model (SEIM) and the Illness Perception Questionnaire (IPQ) (Bhui & Bhugra 2002). The patterns of questioning are similar in these later models, and the differences lie in how they are structured. SEIM has built-in classification features that permit qualitative data. Clinically, explanatory models are not diagnostic tools. In medical and research settings, explanatory models provide the clinicians and researchers with an idea of how patients experience and interpret their conditions. This method lets clinicians improve the quality of cure. It also helps health researchers understand their subjects, and this could help in the design of appropriate therapies or interventions, or explain why some people reject medication or refuse to comply with a prescribed therapy.

Kleinman (1978) in his introduction to the model presented a case study where an explanatory model may be useful in a clinical setting (See the case in methodology section.). Kleinman Kleinman's (1978) model contains eight qualitative open-ended questions as a way to understand how patients view their conditions and their expectations as well as concepts of cure. He came up with these questions in an attempt to distinguish between disease and illness and to bridge the gap between clinical knowledge and construction of clinical reality. Explanatory models can be administered either as an interview or through a questionnaire. The questions are as below.

- What do you think has caused your problems?
- Why do you think it started when it did?
- What do you think your sickness does to you?
- How severe is your sickness? Will it have a long or short course?
- What kind of treatment do you think you should receive?
- What are the most important results you hope to receive from this treatment?
- What are the chief problems your sickness has caused for you?
- What do you fear most about your sickness?

Kleinman observed a gap between medical research and the approaches to more practical solutions, and a mis-match between the physicians' understanding of disease and the patients' experiences of illness in United States. To bridge this gap and to help clinicians break out of their medicocentric views, he proposed his eight-question model as a way to understand how patients view their conditions and their expectations as well

as concepts of cure. Such data could be used to train physicians in improving quality of cure by allowing them a more systematic understanding of social or cultural constructions of illness.

Explanatory Models are able to "integrate clinical, epidemiological and social science frameworks" (Weiss et al. 1992, p. 819) by improving the depth of scientific understanding of disease and illness. Biering (2007), Vlassoff and Ali (2011) state that Explanatory Models are flexible and applicable in many scenarios, such as studying violence in Iceland, HIV-related stigma among the South Asians in Canada, or understanding hypertension and sick roles among Americans. In clinical settings, physicians can use this method to find out what their patients think about their ailments and how they are experiencing their illnesses. This information can help physicians understand their patients' beliefs and behaviors, to facilitate further discussion of an ailment, and perhaps to prescribe more appropriate treatments.

This model is used in qualitative research using other techniques such as life histories, key-informant interviews, participant-observations and focus group discussion among informants. I have used this model considering its usefulness to understand the behavior of people on health problem, illness, injuries, and disability. It is also useful to know how people make sense of their illness experiences, views on health problem and causes and effects of illness. Finally, it is expected that the theory helps to understand the gap between medical research and the approaches to practical solutions on the basis of patients' behavior.

Conceptual Framework

Medical systems are the integral part of all cultures which affect the health status of people. Medical system includes the totality of health knowledge, beliefs, skills and practices of any group. It includes all clinical and non-clinical activities, formal and informal institutions, and other activities that are even remotely connected with ill health of the community. The Hyolmos also have different medical and healing practices which they follow traditionally; and various factors are influencing these practices due to modernity. Based on the above theory, the following conceptual framework is developed to carry out this research, which shows that various medical and healing practices exist in the field as well as the factors which influence the choice of medical system. It also

clarifies the cause of alternation on the peoples' choice with the change of time. The reason to choose any medical system also depends on the peoples' perception on the efficacy of those practices. I have drawn the following conceptual framework about medical pluralism and its causes (see Figure 1).

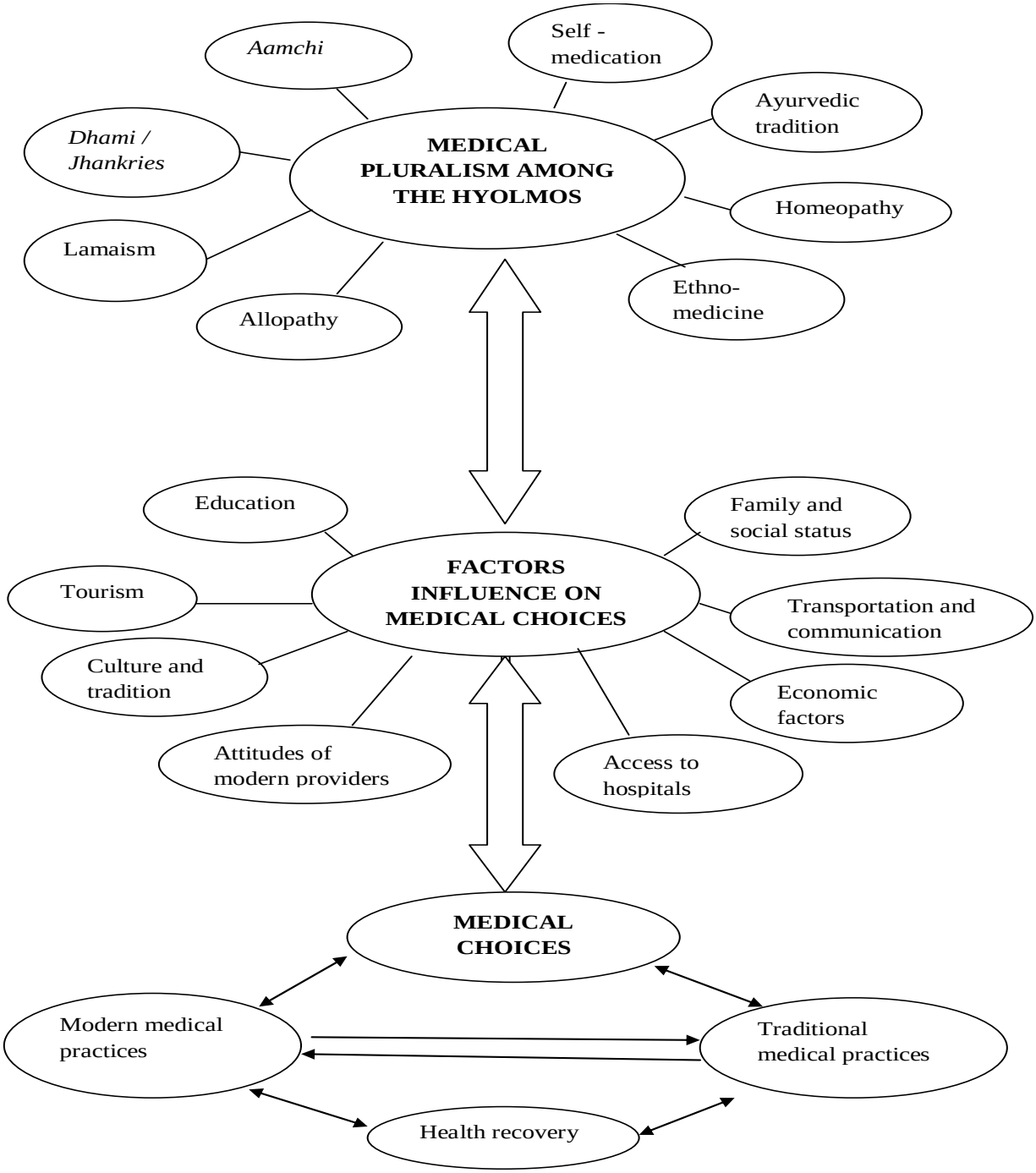

Figure 1. Factors Influencing Medical Choices and their Transformation

The review of literature and fieldwork has explored the existing medical and healing practices, their changing scenario and causes of change related to healing practices. Explanatory Model developed by Kleinman (1978, 1980) is a widely used model that recognizes three overlapping sectors in health care traditions. Kleinman (1978, p. 86) asserts that illness is experienced and reacted into three sectors: the folk/traditional, the professional and the popular. I have incorporated Hyolmos' medical and healing practices within these three sectors since it is part of pluralistic health care system. Folk/ traditional practices include mainly *Dhami/Jhankries*, *Aamchis* and Lamaism. Professional sectors incorporate mainly the allopathic practices; and the popular sectors cover self-medication and various ethnomedical practices.

Among the various factors making influence on medical choices, transportation, communication, education, economic well-being, social status, access to modern treatment, religion, culture and tradition, tourism etc. are taken as the factors related to the choice and change in medical practices. The changes from three to four decades back to the present is analyzed, as they are assumed to be the major factors which have influenced the medical choices of the community people, which determine the health-seeking behavior, peoples' perception towards health care system and the changes in health behavior. Still, there are two major healing practices: traditional and modern. Traditional practices are being replaced by modern ones due to the socio-cultural changes in Hyolmo community. Sometimes people use both types of practices in overlapping way. My argument is that some health seekers seek treatment with both traditional healers and the modern practitioners parallelly or the health seekers also can go to traditional healers after the treatment with modern practitioners as medical choices do not proceed ahead in a linear process. Medical pluralism is caused by various factors and these associated factors create medical and healing options and also change the medical system. Thus, there is mutual relationship between medical choices and influencing factors. The two-way vertical arrows of the conceptual framework show their connections.

Many aspects of Nepali caste, ethnic groups, economy, education, religions, geography, traditions, and development are interlinked and they have played a role in determining medical choices. The conceptual framework shows that it can also be

analyzed in the reverse way because all the health components are interrelated to each other. Whatever the healing practices followed by Hyolmos, they seek immediate health recovery in easier and cheaper way.

Rationale for the Study

This study sheds lights on multi-practices of healing and medication among Hyolmo people, their medical practices and changing patterns due to the various impacts. A few researches have been carried out in the field of medical anthropology in Nepal. This research is expected to add one more brick to understand the health seeking behavior of high hill people anthropologically as theoretical contribution. It explores the existing medical practices among Hyolmos. It also investigates the reasons for medical choices among them along with their economic, socio-cultural and educational background and it analyzes their changing pattern. It will be helpful to understand the multiple aspects of health-seeking behavior. Moreover this study is expected to be the milestone for novice researchers and academicians, particularly those who are directly and/or indirectly involved in medical anthropological sub-field to observe the changing health-seeking behavior.

Medical anthropology is in the stage of infancy in Nepal and related researches are inadequate. Helambu, the study area, is still virgin from regarding this kind of study. Knowing the medical choice behavior and its changes students, researchers, academicians and other interested persons can be benefitted. Therefore, being interested in the practices of medical pluralism, this study is undertaken particularly in the ethnic group Hyolmo, who are the residents of Helambu, Sindhupalchok.

Organization of the Study

This dissertation is organized in nine chapters. The first chapter (introduction) introduces the topic and elaborates the research question. The research questions are followed by general and specific objectives. Theoretical perspectives of this research are illustrated and the conceptual framework is made.

Chapter two reviews the relevant literature. It portrays a general landscape of previous studies in related area from the broader world context, south Asian context, and Nepalese context to the particular Hyolmo context about medical pluralism. Various

medical practices in the study area are reviewed to get the related information through available literatures and research gap. The reviews carried out are the basis of analysis and discussions in different chapters of the dissertation.

Chapter three presents the research design used in this research including universe, census process and the different methods and tools that were employed to collect information. This chapter also incorporates the data analysis process.

Chapter four outlines the socio-cultural setting of the study area including the health and hygiene aspects. It includes historical, demographic, educational, physiographic, religious and other aspects of the study area which have the influence on medical choice directly and indirectly.

Chapter five is about the various existing medical and healing practices in the study area. It is explained and analyzed based on mainly the primary data with reference to some related secondary data. The existing medical / healing practices are categorized into preventive and curative practices and their different categories.

Chapter six explains the peoples' perception about different medical/ healing service providers and their efficacy. The peoples' perception on different illnesses and healers; and the different local healers' perception towards other healers are also analyzed because the perceptions of people towards different healers plays important role in the choice of healers.

Chapter seven discusses the various associated factors which play role in the choice of medical practices and bring changes on health behavior. It includes education, transportation, communication, foreign employment, tourism, link with city area, inter-marriage practices and establishment of health posts.

Chapter eight tries to link the finding of this research with the existing theories and literature. It helps to fulfill the research gap. This chapter tries to explore the new fact similar or dissimilar with the previous studies comparing with theories and literatures.

Finally, chapter nine presents the summary and conclusion of this research. It summarizes the finding first and then underlines the potential theoretical contribution through conclusion.

CHAPTER II:
REVIEW OF LITERATURE

Introduction

In this chapter, the literature related to Hyolmos and plural medical practices is reviewed in detail. Medical pluralism in the context of the world, South Asian, Nepalese, and then of Hyolmos are reviewed on the basis of available literature. It provides information about previous researches and the gap of subject related knowledge, which helped in formulating the research questions, objectives and conceptual framework as well as developing methodology.

Medical Anthropological Tradition

Medical anthropology deals with factors that maintain or contribute to disease or illness, and the strategies and practices that different human communities have developed in order to respond to disease and illness (Baer, Singer & Susser 1977). It elucidates the factors, mechanisms and processes that play a role or influences the way in which individuals and groups are affected by and respond to illness and diseases. Medical anthropology has been traditionally related to the practices of primitive medicine of non-written tradition, that is, the non-Western medical practice. Medical anthropology emerged as an important sub-discipline in anthropology only after the middle of 20th century. It developed while studying the survival strategies of small isolated populations; however, it also helps to understand the health problems of more complex society. It brings better understanding of how social, biological and environmental factors interact and influence on health. Foster (1978) states that the root of contemporary medical anthropology can be traced to three different sources: i) the traditional ethnographic interest in primitive medicine including witchcraft and magic, ii) the culture and personality movement of late 1930s and 1940s with collaboration between psychiatrists and anthropologists, and iii) the international public health movement after the World War II. Rivers (1924), a physician, is considered to be the first ethnologist of non-Western medical practices.

The term "medical anthropology" has been used frequently by anthropologists working in and around the problems related to health and disease in human societies

during 1960s. The anthropological study of health occurrence and means of coping with disease involves itself deeply in how people perceive their world, in the characteristics of the human social system and in social values (Good 1994). In this way, medical anthropology is not only a way of viewing the state of health and disease in society, but a way of viewing society itself (Lieban 1977). Without knowing their perception, their interpretation towards health and illness cannot be understood. For this, one has to study the holistic culture and social organization of health and illness in that society.

Medical anthropology looks at cultural conceptions of the body, health and illness. It also focuses on health behavior as a way to learn about social values and social relations of traditional medical practice. It encompasses the methods of diagnosis and treatment. It focuses on medicine as a set of ideas and practices. Its importance is increasing in the recent years as health and disease are tried to be defined and determined in terms of culture. One should be healthy physically, medically and culturally. There is close relation between disease, medicine and culture. Someone who is healthy in a culture may not be healthy when viewed from another culture. Thus, health is analyzed on the basis of cultural realities. People utilize their culture for existence. Thus multi-cultural environment has multi-medical practices. Thus, model of health and illness are strongly influenced and shaped by cultural factors because belief system and life style are linked with health and disease.

In the past, medical anthropologists tended to study the health problems at local level, and less often at the national level, but now they concentrate more on broader national and international level. Medical anthropologists are interested in different topics of health and illness at the theoretical level such as evolution and ecology of illness, paleo-pathology and social epidemiology, the political economy of health and disease, ethno-medicine and ethno-pharmacology, medical pluralism, cultural psychiatry, social organization of health professions, clinics, hospitals, national health care systems and international health bureaucracies, human reproduction and nutrition. At applied level, they work in community medicine, public health, international health, medical and nursing education, trans-cultural nursing, health care delivery, mental health service, health program evaluation, health policy, health care reform, health activism and advocacy, biomedical ethics, research methods in applied medical anthropology, efforts

to control and eradicate a wide array of health related problems and environmental pollution. As this is an anthropological work, I have reviewed international and national aspects of medical pluralism focusing on particular local practices of Hyolmos.

The above write-up highlights the history of medical anthropology as a sub-discipline, which emerged after the 1950s and it is called ethno-medicine today. The application of its principle is based on primitive medical beliefs and practices. It looks cultural conceptions of body, health and illness.

Medical pluralism. Medical pluralism is the situation where a patient has a number of choices while selecting some system of treatment. The term was coined specifically to describe the treatment avenues available in the early modern age. A person suffering from illness or disease can make a choice of medication from the various potential treatment sources or even choose all the available treatments.

Medical pluralism includes the aspects of both the cognitive and social systems of healing and treatment traditions. The dimension of cognition relates to a wide range of medical concepts, values, attitudes, and beliefs that serve as guidelines for health action and practices. Thus, for one episode of illness, people have different theories of causality from the perspective of various medical traditions. The social system dimension refers to the different economic, institutional and organizational aspects of treatment and health-care delivery system (Subedi 2003).

The fact that pluralistic character of health and medical system exists almost in every society, be it simple or complex, is being increasingly recognized (Minocha 1980). In every society, people have different beliefs, practices and procedures regarding medical practices. It differs in accordance with society, culture, tradition, time, ethnicity and even individual.

Kleinman (1980) developed the Explanatory model, a widely used model that recognizes three overlapping sectors in the health care traditions. The popular sector consists of health care conducted by ill persons themselves, their families, relatives, social network and communities. It includes a wide variety of therapies, such as special diets, herbs, exercise, rest, and baths or over the counter drugs. He has created a useful classification system for healing activities in pluralistic systems. He distinguishes between popular health care sectors where a non-specialized person, usually in the

household, uses a general body of knowledge to cure illness. He then identifies the folk sectors, in which healing is performed by non-professional, non-bureaucratic, specialists who have trained informally or have an experience of cure and treatment. This sector is considered an intermediate level between the popular sector and the professional health care sector. The professional sector involves the highly specialized training and knowledge-based education, where there is formal position of your practice, so social status may be high, depending on the society.

The Explanatory model helps to form a comparative framework for organizing the various roles of practitioners and medical systems**.** It is critical to understand that, although these roles are divided into sectors, they are highly fluid and move between each other to best suit the patients' problems. He states that in "indigenous healing systems" these three sectors have their own unique identities, but there are many areas of fluidity and overlap where healing options can exhibit attributes of more than one of these sectors. Minocha (1980) states that; the general practitioner uses various systems in his or her medical practice. For example, an Ayurvedic practitioner may incorporate the stethoscope, ophthalmoscope and other instruments and drugs that are the products of modern medicine into his or her kit and germ and virus theories in his or her explanatory armory. Similarly, practitioners of modern medicine may explain dietary restriction in terms of hot-cold dichotomy of ayurveda.

The plural cultural practices make the medical practice plural which differs from person to person and society to society. It comprises value, belief and behavior that are created individually within a culture and later are institutionalized. A person or society may be influenced by various factors which enforce to choose any medical and healing practice directly or indirectly.

Medical pluralism in the world. Medicine is a part of culture like any other aspect of culture. It has an element of unrecognized inner rationale, and is influenced by non-medical cultural phenomena in a number of ways. There is considerable body of literature on health-seeking behavior among primitive societies and folk or peasant cultures (Landy 1977). Healers across the world might work on different premises and follow diverse practices. However, the main goal of any medical practice is to treat sickness and maintain good health. Investigators of illness and healing in different

cultures tend to agree that some aspects of health-seeking behavior are universal. All cultures have some shared ideas of what makes people sick, what cures them of these ailments and how they can maintain good health. Development of this kind of cognition among people is part of the cultural heritage of each population, and from it empirical medical systems have been formed, based on the use of natural resources. Laymen as well as health professionals tend to combine the individual models of beliefs existing in their society.

A division of labor exists in every medical system between practitioners who represent different traditions. In the United States, clinical psychologists, yoga teachers, health food experts and Christian Science healers follow various systems of therapy. Cosmopolitan medicine does not meet the demand for health care in the United States, despite its elaborate structure of specializations, extensive facilities and clear professional dominance. For some illness and some kinds of patients, it provides less effective care than one or another "alternative therapy." This is most obvious in psychotherapy (Leslie 1980). It is obvious that biomedicine has not covered the remote areas of developing countries, including Nepal.

Cultural processes play explicit role in sickness and health. Illnesses are constructs of belief and knowledge, which vary with time and space. Illnesses could well be attributed to the evil eye, magic or offending some deity, the treatment for which could be through folk medicine or magico-religious methods in rural areas.

Franco (2009) states that medically pluralistic systems often create a framework where exchanges of ideas and methods become normal, thus biomedical practices concentrate on an intricate mix which results in new hybrid systems or modifications to the existing ones. In some countries these exchanges have facilitated the creation of new systems that combine traditional and biomedical explanatory models. This type of integration and exchange will be, and is fast becoming, a common occurrence in many cultures. The ability of these healers to compete with the dominant biomedical practitioners has created new choices for people. For example, amongst the Wagogo of Tanganjika (Africa), the doctor takes his patient to the crossroads along with herbs. He prepares medicine with the herbs and administers a part of the prepared medicine to the patient (Panzer 1968).

In most of the industrial nations, quality medical care is available, but access to it differs among rural and urban populations, members of different social strata and ethnic groups. The cost of eliminating these variations by fully utilizing scientific knowledge to meet all needs is greater than the expenses that the wealthiest industrial society is willing to pay. In all societies, therefore, compromises are necessarily made in allocating medical resources (Leslie 1980). It is stronger in the case of developing countries where local medical systems are largely composed of indigenous practices because the costly industrial medicine is economically inappropriate.

In People's Republic of China, the traditional Chinese medicine has been incorporated as sanctioned medical system. The idea is to consider "irregular medicine" in a more objective sociological manner. All medical systems can then be conceived as having pluralistic structures in which cosmopolitan medicine is one component in competitive and complementary relationships to numerous "alternative therapies" (Leslie 1980).

The different empirical medical systems around the world have been developed by observation and experimentation of millions of people, their conceptions, as well as knowledge of plants, animals, and minerals. People have started different practices to be healthy or to cure diseases from the remote past. As a result, medical pluralism was developed. Medical pluralism is found worldwide and prevails in each continent, country, society and individuals. It is more prevalent in folk or peasant culture.

Medical pluralism in India. India is almost similar to Nepal from various perspectives, including from a medico-cultural point of view. The origin of medical practices in Nepal has the same roots as in India in Ayurveda. Therefore, medical pluralism in the Indian context is reviewed here so that it is helpful to know the medical pluralism in Nepal.

India has different medical practices in both rural and urban areas. Ayurveda, Unani, Siddha, and homeopathy are identified as Indian Systems of Medicine by the Ministry of Health and Family Welfare and, since 2003, as Department of AYUSH (Ayurveda, Yoga, Unani, Siddha, and Homeopathy). Full discussion of the history, theories and methods of these systems is of academic, medical and scientific interest and may illuminate the contemporary interest in complementary and alternative medicine. At

the time of Indian independence, in 1948, the Bhore Committee established the direction of India's health system without examining the role for traditional medicine, as has been frequently noted (Taylor & Leslie 1973). Nonetheless, individual states continued support for traditional medicine and, by the 1960s, political activism on the part of leading Ayurvedic and other traditional practitioners led to the establishment of a central government ministry for the Indian medical systems. The physicians, colleges, research institutes and hospitals supported by this ministry may be identified, as Leslie (1976) called them, as primarily 'urban' and 'elite.'

Thus, traditional practitioners, as D'Cruz and Bharat (2001) suggest, take on the appearance of biomedical practitioners, by the use of stethoscopes and modern drugs like antibiotics, which they are often ill-equipped to use. As a recent study of practitioners in Mysore shows, the incorporation of modern medical instruments and treatments in traditional practice is expected, but often serves as symbols, which are not used, or used incorrectly. The reality on the ground is that a cadre of ISM & H practitioners serves as a secondary part of the health system, "a health reserve" to which urban patients turn when biomedicine fails to cure (Nisula 2006). Ager and Pepper (2005) state that in the situation faced by rural patients, such as those interviewed in a study conducted in rural Orissa, the reputation, proximity, and affordability of the medical practitioner explain their use of both biomedical and traditional services.

However, in the rural areas, most practitioners are unqualified, and when the monsoon, or lack of funds, prevents access to more distant or costly health services, these are the practitioners of resort (Ager & Pepper 2005). Thus, there is a need for regulation of medical practice, and of the use of drugs and treatments that are not within the repertoire of ISM & H. And, as discussed above, there is a need for strategies to ensure the availability and access to efficacious medical care. A report (World Health Organization [WHO] 2002) estimates that 70% of the population in India uses traditional medicine. This figure is based on a survey conducted by the Institute for Research in Medical Statistics at the request of the Department of ISM & H covering 35 districts of 19 states, a total of 45,000 sick persons in 45,000 households. This study has also identified the reasons given for using traditional medicine as showing "no side effect" and "low cost of treatment" (Singh, Yadav & Pandey 2005). Leslie (1980) states that;

there are eighteen varieties of practitioners in South India. They had complex set of traditions that they used to interpret, prevent and cure illnesses. Two kinds of registered practitioners used allopathic medicines. One was self-instructed, while the other had a course of training in homeopathy.

In a research in Karnataka on health inequities, Sen and Colleagues (2007) have identified a system of "forced pluralism" in which they found "spiritual and traditional healers, shopkeepers selling tonics and tablets, traditional birth attendants and RMPs (registered medical practitioners). A provider survey interviewed 548 providers working in 60 villages covering a population of about 82,000 people. This included 35 spiritual healers, 133 traditional healers, 178 traditional birth attendants, 47 RMPs, one qualified Ayurvedic doctor, 152 provision stores and two medical shops. In a study carried out in an urban community in New Delhi by Das and Hammer (2007), an effort was made to determine the clinical decision making of various types of practitioners trained in biomedicine and in traditional systems as well as that of registered medical practitioners with minimal training, when faced with five typical medical problems. This study, although not solely focused on the traditional systems of medicine, again highlights the dilemma of forced pluralism, and also points out the socio-economic divide evident in patients' choices and their access to competent physicians.

When patients' use of traditional medicine was first studied in India, social scientists were researching the socio-cultural explanations for the persistence of traditional medicine. Socio-cultural programs were promoted even as programs to support biomedicine. Banerji (1974) criticized these social scientists for diverting attention from the failure of the health system. He argued that the inadequacy of the primary healthcare system, in particular, was the reason that rural Indians and others turned to traditional medicine. The fact was that the governmental services were miserable and wholly inadequate to community needs.

In India, natural or supernatural forces explain illness. The indigenous legend of tribes of Rajasthan allege that illness results from humoral imbalances stemming from diet, climate, social offences, life activities, astrological and imperceptible forces, spiritual action, witchcraft and sorcery. Accidents, disability, calamity, diseases and losses are readily explained by holding some elements of supernatural causes. Similarly

tribes classify some diseases like cold, fever and other respiratory infections as illnesses of cold (*sardi ki bimariyan*); and problems like boils, ulcers, piles, genito-urinary disorders are believed to be the illnesses of heat (*garmi ki bimariyan*). These illnesses are alleged to be caused by excessive internal cold or heat in the body respectively. The cold or heat does not correspond to body temperature but rather to the internal humoral state (Bhasin 2005).

Spirit possession is common in India. In the tradition of spirit possession, icons as well as effigies are used to communicate with, and to symbolize, good and evil spirits. In ritual exorcism, mediums make effigies of the victims and offer the gifts attractive to demons. Cultural history of the people, their gods and goddesses, and myths or powers of any of the goddesses decide why or how they choose certain individual to become ritual specialists (Bhasin 1997). The tribal people practice the healing powers of spirituality and go to the spiritual healer for healing.

Today, Indian traditional medicine, such as Yoga and Ayurveda, are popular health options in the Western societies, and continue to serve the health needs of people in Indian society. For the urban, middle class Indian patient, traditional medicine may serve as a healthcare option that addresses socio-cultural beliefs. For the rural Indian patient with low income, traditional medicine may be the major option to meet health needs.

The above literature clarifies that all the Indian societies have plural medical practices either in rural or in urban areas, either by trained medical practitioners or by traditional healers. Patients of lower economic level have faced the choice of less qualified and less competent physicians than the richer patients. The patients are obliged to choose different medical practices due to various circumstances. In the rural area of India, people are compelled to follow traditional healing system mainly based on religions, but in the urban area they mostly depend on modern providers. Whatever the curing system they follow, traditional, religious or modern, plurality of medical practices is found everywhere.

History of Medicine in Nepal

The history of medicine can be considered fairly long in Nepal. From the *Ramayana* one learns that Hanuman was told to bring the *Sanjeebani Buti* from the mountains in the

Himalayas. It shows that many herbal medicines were in use then in these lands. Most of the medicinal plants used in Sri Lanka are similar to the ones used in India and for that matter in Nepal. It has been said that Lord Buddha (563-477 BC) used to attend regularly to all the sick disciples in his camp. Buddhist hospitals in India existed before the invasion of Alexander the Great. It is to Gautam and his followers that we owe apparently the hospital idea (Dixit 1995). One of Buddha's disciples King Ashok is credited to having established charitable hospitals for both men and animals (Keswani 1974). It is the Ayurveda, or "the science of life" system of medicine, that is found in this part of the world today. It has been recorded that *Arogyashala* or Ayurvedic hospital existed in Nepal during the reign of Amshu Verma (605-620 AD) of the Lichchhavi period. Pratap Malla (1641-1674) established an Ayurvedic dispensary in Hanuman Dhoka complex (Marasini 2003).

Allopathic medical model was developed recently as a conceptual tool for the analysis of bodily problems for allopathic medical practitioners in Nepal. In this tradition, medical treatment is based on the theory that a disease can be carried from person to person, through the air, the blood, bodily secretions or from contact with a septic object or substance. As Gellner (1994) states, the allopathic medicine was introduced officially in Nepal at the end of the nineteenth century when Bir Hospital was established in Kathmandu. Organized development of allopathic services started in the mid-1950s. This system is formally associated with the public health care delivery in Nepal, through the Ministry of Health and a number of private offices staffed by physicians, public health professionals, nurses, midwives, health assistants, pharmacists, village health workers, and trained volunteers (Dixit 1995).

Homeopathy is also the traditional medical treatment practiced in Nepal for long in history. It started in Nepal during the eighteenth century and is based on the concepts concerning balance and imbalance in the body. Nepali government has institutionalized it with hospitals and clinics throughout the country. The homeopathic medical tradition was originally founded by a German physician named Samuel Hahnemann. According to the homeopathic tradition, in order to treat an illness a homeopathic practitioner must create a diluted solution for the patient to take based on the “law of similar,” this means that any

remedy made must be out of a substance that produces the same symptoms as the actual illness (Gewali 2008).

Ayurvedic treatment in Nepal began in the Vedic period, as ayurveda is one of the sub-divisions of Veda. Herbal Medicine and Yoga also have a long history. These practices were systematized gradually in the various phases of Nepalese history.

Allopathic medical practice began only with the establishment of Bir Hospital. Now it is increasing along with the advancement in modernization, but Ayurvedic and herbal medical practices are also equally popular because of their perceived absence of no side effect.

Medical Pluralism in Nepal

Various authors have claimed that the concept of medical pluralism can be applied to various groups of Nepalese population (Acharya 1994; Blustain 1976; Dhungel 1994; Durkin-Longley & Maureen 1984; Pigg 1995; Stone 1976; Streefland 1995). There are some similarities and dissimilarities in their nature.

Medical pluralism comprises the ideas, values, and behaviors that are created by individuals within a culture and are institutionalized into real practice. The concepts within the different medical systems and the people operating within these systems create their own medical concepts; and these concepts are frequently a unique mix of the different medical systems inherent within their cultural context (Burghart 1996; Rashid 2008; Weller, Ruebush & Klein 1997).).

The existence of several therapeutic traditions in a single cultural setting is an especially important feature of medical care in the developing world (Leslie 1978). Patients may have the feeling of uncertainty regarding what type of care provider can cure their illness; and such a feeling leads them to consult different medical therapists. Or, they may decide that treatment of certain illness requires more than one type of assistance. Generally, care is sought from several types of providers and medical traditions concurrently or sequentially. The practitioners of different medical traditions may interact with each other in a variety of ways. At times they can exchange the ideas and knowledge from one another, compete with and oppose the other system. Or they can also cooperate with one another in developing referral systems, or they may simply co-exist independently of one another (Kleinman 1980; Levitt 1988; Subedi 1989).

Different medical traditions in Nepal co-exist. Each tradition has its own expertise, especially in certain illnesses. There are various factors which influence or determine the choice of healers, including the perception of villagers towards health care personnel, the cost of treatment and the quality of service they will get. Subedi (2003) states that, in many cases, the question of which specialist to consult depends on the nature of illness. For example, most of the people seek Ayurvedic *vaidya* or *kaviraj* for jaundice, and *dhami-jhankri, janne manche, jharphuke vaidya* or other local healers for *lagne* or evil spirits. Minor discomfort, wounds and sores are often treated at homes with foods and herbs; but the hospitals, clinics or health post (allopathic healers) are consulted for more serious injuries.

Subedi (2001) states that health practices in Nepal comprises a wide range of medical beliefs, knowledge and practices and of distinctive categories of functionaries including medical doctors, health assistants, nurses, dispensing chemists and pharmacists, acupuncture therapists, Tibetan medical practitioners, Ayurvedic practitioners, Unani medical practitioners, folk healers, tantric healers, spiritual healers, *Dhami/Jhankri* (shamans), herbal-doctors, traditional birth attendants and other practitioners. These doctors and healers use different forms of diagnosis, therapy and medicines. They elaborate, develop and modify the old traditions and make new ones.

Nepali illness beliefs and practices have been influenced by many different sources throughout the history. Most of the modern inhabitants of Nepal trace their ancestry back to various waves of migrants who brought with them, from their origin, many beliefs and practices regarding illness. The influence of these illness beliefs and practices is still evident in the various medical systems that are in use even today throughout the country (Beine 2003). The original Bodic-speaking people of the pre-forth century Mongolian origin, who brought with them central Asian shamanistic practices that are still evident in some of the healing practices observed among shamans today (Streefland 1985; Watters 1975). Likewise, the Khas tribes, who started settling in Nepal around 2000 BC, brought with them ancient Ayurvedic traditions are still widely practiced today (Dhungel 1994; Streefland 1985). Waves of Muslims brought with them the Greco-Arabic medical beliefs and practices that are evident in modern day homeopathic medical practices (Blustain 1976). Later, waves of migrants from Tibet

brought the Tantric Buddhist ideas about healing with them (which combine the elements of ancient Chinese medicine and shamanistic practices of the early Bon and Lamaism religions) that are still popular today (Durkin-Longley & Maureen 1984; Streefland 1985). And recently, the allopathic ideas of Western medicine have been introduced and well accepted (Dhungel 1994; Pigg 1995; Streefland 1995).

The general character of Nepali medical system is pluralistic in nature because certain variations in medical knowledge, beliefs, specialization and curing practices are found in almost all societies in Nepal, and the Nepalese societies have incorporated the new ideas and utilized various treatment procedures nowadays.

Foster and Anderson (1978, p. 53) have broadly categorized the non-Western medical system into "personalistic" and "naturalistic" dichotomy. In personalistic system, illnesses are believed to be caused by the intervention of a sensate agent: supernatural beings (gods or deities), other non-human beings (ancestors, ghosts or evil spirits) or human beings (sorcerer or witch). In naturalistic system, diseases are caused by natural, impersonal phenomena such as disruption of the body's equilibrium. Both these systems are prevalent in Nepal. Personalistic system is practiced mainly in the rural areas and naturalistic system is more prevalent in urban areas. Some people and community practice both the systems.

Medical pluralism influences the choice and decision to seek different health care services. It is because of multi-tradition and multi-culture. The government-funded health care systems are also pluralistic in character. There are multiple health services provided by the government; allopathic as well as homeopathic and ayurvedic treatment systems are prevalent. Steele (2011) has categorized the pluralistic medical practices as shown in table 1.

Table 1: ***Pluralistic Medical Practices***

State Recognized Medical Systems	**Description of Medical System**	**Therapies Offered**
Ayurveda	Body is comprised of a certain amount of tissues, elements, and wastes. These must be kept in balance for a person to be considered healthy.	Lifestyle changes, herbal remedies and supplements, nutritional changes, yoga, meditation, hygiene, and minor to major surgical procedures
Homeopathy	Illness must be treated through "remedies." Remedies are based on the "law of similar." This means that an illness must be treated with a diluted solution that causes the same symptoms as the illness.	Diluted solutions in the form of tonics or homeopathic pills upon which a drop from a remedy solution is placed.
Unani	Based on the concepts of the four humors: phlegm, blood, black bile, and yellow bile. Illness is caused by an imbalance of these substances.	Four types of therapy: regimental, diet, pharmacotherapy, and surgery
Traditional or "Folk" Medical Systems	**Description of Medical System**	**Therapies Offered**
Shamanism	Illness is caused by malevolent forces, jealousy, the evil eye, and spirit possession.	They will prevent illness through the use of amulets or incantations, and they will heal illness through the use of exorcism and other rites.
Religious Healers (Hindu or Buddhist)	The origin of illness is spiritual and a result of the cosmic forces of each respective religion.	Healing is accomplished through prayers, blessings, and offerings.
Vedic Astrologer	Illness is karmic or destined and an astrologer knows about your illness through your astrological chart.	One can do one or any of the following depending on the illness: performing fire rituals, charitable acts, fasting, giving to the poor, or wearing special amulet.

All systems of treatment do not exist to an equal extent in all parts of Nepal. The local indigenous system and faith healing system exist to a greater extent in rural areas than in the modern medical or Ayurvedic systems. No matter whichever the healing system one finds in a place, there is a pluralistic medical setting in which people must make their health care choice.

Medical Pluralism among the Hyolmos

Bhasin (2007) says that in most tribal communities, medical care, treatment and aetiology of diseases are defined within the social context. It is important to identify the processes by which the tribal people recognize sickness and the ways to counteract it. The illness could well be attributed to the evil eye, magic or offending some deity, the treatment for which could be through folk medicine or magico-religious methods.

The pluralistic character of health and medical system in almost every society, be it simple or complex, is being increasingly recognized (Minocha 1980). There is plural cultural character in Nepal, which is reflected in the medical practices and treatment procedure as well. In the several contexts of illness treatment, Nepali villagers easily combine the Western medicine with traditional practices (Stone 1976). In order to understand the health care choice people make during their health complication episodes, it is important to recognize the various medical traditions which influence people's medical decisions. As Hyolmos are Tibetan Buddhist culture followers, they also use religious ideas of healing. In Hyolmo community, the several medical traditions with their independent classification of illnesses, concept of disease causality, diagnostic methodologies, practitioners and treatment therapies present the health seeker with a wide range of alternatives to choose. The medical practices of Hyolmo people are influenced by the recently constructed rough road, access to electricity and means of communication such as telephone and television, economic prosperity, tourism and migration. Because of these factors, the Hyolmos who depended only on limited medical practices have diversified their medical practices.

Foreign trekking expeditions through this region and employment in Kathmandu, India and elsewhere have brought additional sources of material wealth for the Hyolmo people. In the last three decades, an ever-increasing number of Hyolmo families have settled permanently in Kathmandu, primarily in the Tibetan neighborhoods that surround the great chorten in Bouddhanath (Desjarlais 2003). The processes of migration, trekking and tourism have brought the modern influence in every aspect of culture, including medical practices. This implies that traditional medical practices are changing into modernity.

Below are descriptions of the medical settings and their associated traditions based on the above literature. Various factors are influencing the choice of treatment options. One such factor is the perception of villagers about health care personnel. Other determining factors are the cost of treatment in relation to what people can afford and the quality of service they will get. The actual cost of using the services, those of reaching the services, the loss of money which could have been earned in the same time, availability and access of treatment and many more factors are important in medical choice. It should be noted that there are wide variations in practices and the beliefs among different ethnic groups found in the country.

Dhami/Jhankri. There exist various sorts of traditional faith healers in Nepal such as *Dhamis, Jhankris, and Jharphuks*. The *Dhami-Jhankris* exert a lot of influence regarding health matters. *Jhankris* are Himalayan shamans, the intercessors who rely on extensive training in oral text to diagnose and treat afflictions that trouble their clients. *Jhankris* accomplish their intercessions through diverse rituals, ceremonies that prominently incorporate throughout every stage of activity both long, publicly chanted recitals and short, whispered, secretive incantations. Shaman texts not only tell stories of the origin on men and of mustard seeds, they also relate the creation of the universe and of its elements. They tell the origins of worldly disorder and the histories of malevolent forces, stories that explain why people suffer, grow old and die. They tell about extraordinary events and exceptional individuals (Maskarinec 1995). Justice (1986) mentions *jharne* and *fukne* for this treatment system. She found that the patient generally waits in the house to get well using herbal and dietary remedies.

It is believed that they communicate with spirits, recite mantras and cure the patients. Most *Jhankris* perform at night. They speak, chant, whisper and shout during the performance. They play significant role in the treatment of rural people. Treatment is done by chanting mantras and shouting at the spirits ordering them to leave the person's body, violent exorcisms by which the patient is burned, frightened and beaten until the spirits flee the patient's body, and by giving offerings and doing sacrifices.

The significant role of local healers has been widely noted (Blustain 1976; Okada 1976; Stone 1976; Wake 1976) in different parts of Nepal. The sick persons in the rural areas who eventually visit the allopathic healers are more likely to consult the traditional

healers as the first hierarchy of resort. The role of traditional healers is complementary to both priest and doctors. They are called the barefoot doctors. Some research works have been done in using them for health education, family planning and treatment of diarrheal diseases. It is estimated that in 1978/79 there were between four and eight hundred thousand faith healers in Nepal (Shrestha & Lediard 1980).

Jhankris as the shamanistic curing system is a common feature of Nepal's Hindu lowlands, and its penetration into the northern border areas reveals Hindu influence upon these regions. *Jhankris* do not play a prominent role in upper Thak Khola at present, perhaps because the Hinduization campaigns of the salt monopoly era lost momentum some decades ago (Parker 1988).

Aamchi. *Aamchi,* a traditional practice, is a humoral medical system from Tibet, whose basic philosophies resemble those of Ayurvedic medicine, and, to a lesser extent, the traditional Chinese medicine. Its principle is that the body becomes hot or cold as a result of eating hot or cold food. '*Aamchi'* also refers to its practitioners. *Aamchi* means doctor in the Tibetan language. An *Aamchi* is a practitioner who has undergone a long period of study under the guidance of a teacher. They have learned *Lama bidhya*. It needs a minimum of five years formal course to become *Aamchi*, nine years course for *Aamchi* teacher and the fifteen years course to become the *Aamch*i specialist. They learn both theoretical and practical knowledge. The average village, however, relies on a religious text written in classical Tibetan, which contains instructions for the treatment of all kinds of disorders (Parker 1988).

The process of diagnosis resembles that of biomedicine; *Aamchis* (sometimes referred to as doctors of Tibetan Medicine) usually identify disorders after understanding a patient history, performing a physical exam, and often doing various tests. They observe the patient's eyes, tongue, wrist, urine and stool to know the symptoms and heal the patients of sugar, pressure, fever, common cold, fracture etc. They treat everything except for the case of scissoring. *Aamchi* gives emphasis on both social and personal balance and physicians may prescribe changes in diet and behavior or perform a number of physical procedures (including acupuncture and minor surgeries) to restore a patient's balance. *Aamchi* is first and foremost a herbal system, and the practitioner's first recourse

is generally to herbal preparations he creates himself in consultation with ancient Tibetan texts.

There is an *Aamchi* practitioner in Hyolmo community, but he has not received formal education. He heals patients on the basis of experience and the informal knowledge he has.

Buddhist healing is popular among Sherpas. Since the availability of shamans has decreased in recent years, Buddhist healing has benefited greatly from the recent upswing in the strength of the monastery system. Influxes of foreign cash have helped rebuild and expand the traditional monasteries, which train many young Sherpa men even if they intend eventually to marry and lead a secular life (Fisher 1997, pp. 59-60). While his description comes from the Khumbu Sherpa and not the Hyolmo, the two groups are both geographically and culturally contiguous. There are some similarities in their healing practices.

Self-medication. Self-medication is one of the oldest practices of treatment which prevails more in remote areas. It is the use of medicine without consulting the medical persons or professionals. The ill person uses household production for treatment which is in the person's access; and practices of various forms of treatment are associated with his or her social power in relation to other household members. The household members cooperate and compete for resource in order to restore, maintain and promote health because if they have to go out for treatment, it would be the burden of fees for medication, diagnosis and examination, transportation cost**,** arrangement for accompaniment, and loss of a worker (more likely of two workers) in wages of housework. All these factors, and no doubt more, can influence health-care seeking decisions (Subedi 2003).

Self-medication includes home-made herbal remedies and tonics, which is more prevalent in rural context. People use basically herbs and home-made medicine in the major self-medication practices in Nepal. Their medical traditions and practices are also based on religion and beliefs regarding cosmos. Generally such medical problems are first treated at home with some remedies suggested by relatives and neighbors. When several attempts of self-medication fail, then they go to specialist for treatment.

Ayurvedic traditions. The word "Ayurveda" is derived from the Sanskrit root *Ayuh* (life) and *Veda* (knowledge). It is the science of life which traces its roots on Vedas. Ayurveda is also one of the world's oldest medical systems with its origin dating back to 1,500-900 BC (Gewali 2008). It was first recorded in the Veda, the world's oldest existing literature. The three most important Veda texts containing the original and complete knowledge of Ayurveda, believed to be over 1200 years old, are still in use today. These Ayurvedic teachings were customarily transmitted orally from teacher to student over 1,000 years. The wisdom of Ayurveda is recorded in Sanskrit, the ancient language of Himalayan Pradesh (India and Nepal) that reflects the philosophy behind Ayurveda. It is considered as one of the best systems of medicine alternative to allopathic treatment today.

Ayurveda has evolved in Nepal from the ancient time. Historical research has shown that king Pratap Malla and Malla kings of Bhaktapur and Patan encouraged Ayurvedic system of medicine by asking to prepare books on Ayurveda and creating opportunities for professional training (Marasini 2003).

According to the Ayurvedic tradition, which has its roots in the Hindu philosophy, all things within the universe are comprised of five elements. These elements are: *prithivi* (earth), *jala* (water), *agni* (fire), *vayu* (air), and *akasa* (ether). Ayurvedic medical knowledge also states that the human body comprises of these elements. As explained in the ayurvedic medical tradition, a person's body is composed of *prakriti* (the female component of the cosmos which forms the body) and three *dosas* or humors of *vata, pitta* and *kapha* (wind, bile, and phlegm), which are responsible for all bodily processes. The equilibrium of the *dosas* maintains health and imbalance results in ill health. In this tradition, diseases or disorders are caused by physiological imbalances resulting from poor food habits, environmental changes, and shock to the system. Diagnosis is done by pulse reading, physical examination, and appraisal of symptoms. Disorders are treated with herbal medicines, diet control, lifestyle control, surgery, meditation, and changing one's environment (Subedi 2003).

There are two types of practicing Ayurvedic practitioners in Nepal. *Vaidyas* are those who are trained professionally in colleges and universities and *Kaviraj* are those who have been informally trained by gurus or their families. Either trained persons or

practitioners from three generations could only practice Ayurveda in the past in Nepal. From the time of King Jayasthiti Malla, in the second half of the 14th century through the end of the Rana regime in the 1950s, only the high caste elites were permitted to enroll in formal education. Therefore, *Kabiraj* were not from low caste and ethnic groups. Some low castes might have hidden their originality of caste to get Ayurvedic knowledge (Cameron 2009).

Nepalese people believe in the efficacy of Ayurvedic treatment in the long run, that is, as capable of achieving more permanent healing with no harmful side effects. It is the established healthcare system in Nepal. Nepal government has formally recognized this medical tradition. However, fewer resources are allocated to this system of medicine than to allopathic medicine. It is one of the popular alternative medical practices in Nepal. It is getting popular in the urban areas but is not prevalent in rural villages.

Homeopathic and Unani traditions. Homeopathy is the next traditional medical system currently practiced in Nepal, and it is recognized by the Nepali government too and institutionalized in hospitals and clinics throughout the country. It was introduced in Nepal as early as 1920 as a natural healing system. Its healing is largely a private sector initiative, which encompasses approximately 500 practitioners and 100 clinics in Nepal. Within the public sector, there is only one homeopathic service facility with hospitalization facilities for six patients (MoH 1997).

The homeopathic medical tradition was originally founded by a German physician named Samuel Hahnemann during the eighteenth century and is based upon concepts concerning balance and imbalance within the body (Gewali 2008). The most important part of the homeopathic regimen is the “remedies” that are produced by its practitioners. According to the homeopathic tradition, in order to treat an illness a homeopathic practitioner must create a diluted solution for the patient to take based on the "law of similar," this means that any remedy made must be out of a substance that produces the same symptoms as the actual illness (Gewali 2008). For example, if a patient experiences food poisoning, a homeopathic practitioner would make a remedy for the patient made out of herbs and other substances that would induce the same symptoms as the food poisoning, except that the solution would be diluted several times.

Unani is also an officially recognized medical system in Nepal. Originally created in Greece, it is a medical system that was later altered and expanded upon by other Arabic cultures. According to Unani, disease is a natural phenomenon and symptoms are created in the body in response to the disease. Unani also posits that the body must be in balance. Instead of having forces or elements, the body possesses four humors. These four humors are: *dam* (blood), *belgham* (phlegm), *safra* (yellow bile), and *sauda* (black bile). Diseases are diagnosed in Unani through the practice of pulse reading and also through the examination of urine and stool samples. The treatments that are offered by Unani can be placed under four types of therapies: regimental, diet, pharmacotherapy, and surgery (Gewali 2008). The Unani healing tradition, with preventive, promotive and curative services, has an extremely limited reach.

Allopathic medicine. The allopathic medicine, or Western medicine or biomedicine, is based on the germ theory of disease and studies of anatomy and physiology. Health is defined with reference to certain physical and biochemical parameters, such as weight and height within which the individuals are normal and healthy. Above or below the normal ranges brings abnormal condition. Diagnosis is carried out by examining signs and symptoms; physical examination; and doing laboratory tests. Treatments are given through injections, medicines, blood transfusion, surgery, electric shock, bed rest and by recommending changes in behaviors or diets, and physiotherapy.

It is a relatively new development in Nepal. It was introduced in the South Asian region by religious missionaries in the sixteenth century and by British colonialists during the latter part of the seventeenth century. This exposure was very limited and was isolated to the specific regions and locales in which the individuals belonging to the missionaries and colonial functionaries lived and worked. Western medicine became an official institution in Nepal in 1947 when Prime Minister Bir Shamsher built the first hospital of this kind, Bir Hospital, in Kathmandu. Several other hospitals were built afterwards in the regions of Teku, Birganj, Jaleshwar, Hanuman Nagar, and Nepalganj (Marasini 2003).

The growth in the accessibility of Western system of health care occurred during the years of 1951-1963, when the Nepal government relinquished some of its control over

Western health care development and allowed private sectors, foreign interest groups, and non-governmental agencies to be able to provide health services and create and build Western medical facilities. Training facilities for Western medical professionals also began to be established during this period of time. Previously, most of the doctors, nurses, and other specialists who worked in the country were foreigners and largely from India. In 1963, there were 32 hospitals and 104 health centers in the public sector in Nepal and the figures have been growing since then. For example, some of the country's major hospitals were built very recently. Tribhuvan University Teaching Hospital was built in 1986; Nepal Medical College Teaching Hospital was built in 1997; Bharatpur Medical College Teaching Hospital, and Kathmandu Medical College Teaching Hospital were built recently (Marasini 2003). Nepali people have a considerable faith in the technology of allopathic medicine, particularly in injections and antibiotics (Gellner 1994).

Allopathic medical facilities, pharmaceuticals, and trained personnel, however, are neither reliable nor easily available in rural areas. Almost fifty percent of the country's doctors, most sophisticated and large private nursing homes and hospitals, trained medical professionals, and the health facilities are concentrated in the Kathmandu Valley. Government-run health services provide care unevenly in the countryside; it is remote and inconvenient for allopathic practitioners (Pigg 1995). Nepal government has made much concentrated efforts to establish health posts in rural areas too. Nowadays health post has been established as one of the major alternative choices for people's treatment of diseases.

Other healing practices. Nepal has a diversity of healing practices. Besides the above mentioned sectors, there are other treatment practices as well. Illness is diagnosed and cured by *jyotisis* (astrologers), *guru-purohits* (priests), or monks through prayers and rituals. The world of magical spirit affects health and can cause illnesses through the network of angry ghosts (spirits of persons who have died in violent or other unnatural deaths), monster-like *bhut-prets* (spirits), angry gods and anti-gods, and *bokshis* (witch-person who can cast evil spells by performing inverted religious rituals). In addition, the Tibetan healing tradition, acupuncture therapy, Japanese healing cults (Seimeiko), and naturopathy are also practiced in the selected areas of the country.

All the options listed above are separate and distinct. All sorts of practices are not prevalent in every place of the country. Particularly the rural people of the country do not have easy access to all. They are compelled to follow the treatment practice whatever available in their area.

As allopathic hospitals are mostly located in city areas, in rural areas of Nepal a large numbers of indigenous and traditional forms of health care and alternative medical systems are in practice. These include: Ayurvedic medicine, Shamanism, Unani, homeopathic healing, Buddhist/Hindu healing rituals, and Vedic astrology, which are the factors attributing to the country's medically pluralistic structure (Gewali 2008; Pigg 1995; Subedi 1989). It shows the limitation of the access of this practice in rural areas.

Factors Influencing the Medical Choices

Various factors play important roles in choosing any medical practice by individuals. It depends on the person's interest, referral cause and socio-economic and cultural factors. The major influencing factors are indicated below.

Person's family and social status. Some critical medical anthropologists have used Marxian and Foucauldian analyses to question the power dynamics and hierarchies they consider being inherent in medical pluralism. Even within a single medical system, social stratification may influence people's access to cure and treatment. Farmer (2004) has remarked that the poor, oppressed and marginalized invariably have different access to medical care: their traditional medicines are frequently denigrated in the name of 'progress,' but their access to 'modern' care (usually biomedicine) is usually restricted and the quality of that cure becomes substandard.

All members of the family do not get equal healthcare opportunities. A member's access to health care is often influenced by his or her position in the household. One member may receive immediate treatment or more expensive treatment, while another member may receive cure only if the symptoms are prolonged or may receive less expensive treatments, such as home remedies. Since members' statuses vary within the household, it makes influence on the impact of their illnesses, and then their access to treatment also differs. Further, a person's position within the household not only influences his/her access to medical care but also influences his/her sick role behavior.

Although there are significant variations among households with regard to their social, cultural and economic 'capital' (Bourdieu 1977), one of their dominant concerns is biological reproduction. Subedi (2003) states that households exclusively support the children, old and disabled members of the family. Almost all households, at least at the initial stage of illness, utilize a fairly wide stock of inter-generationally transmitted as well as newly acquired knowledge and practices of healing to treat the ill person back to good health.

The family structure (patriarchal or matriarchal), persons' social status, and network and resource mobilization capacity determine health seeking behavior. It creates right and obligations as well as emotional involvement for individuals to each other in the community.

Economic factors. Nepal features among the poorest countries in the world in terms of human development (UN 2008). Nepal's human development indicators remain well below the average for the South Asia region: with more than 40% of the population living below the national poverty line.

Consumers' economic level is one of the major determining factors for the choice of treatments. In the developing countries like Nepal, where the majority of people live in poor economic conditions, costs of medical doctors' fees, pathological test, and medicines are usually beyond their capacity. The costly nature of allopathic medicine plays an important role for not consulting the allopathic medical practitioners in the case of poor section of society (Subedi 2001).

Economic and social factors also play a key role in health and medical issues in Nepal and the country's population faces a great deal of social and health care problems. The country has a large burden of disease consisting of both communicable and non-communicable types with vector borne diseases such as malaria and Japanese encephalitis being a major problem as well as those of heart disease, HIV/AIDS, tuberculosis and diabetes. Other health related issues such as high infant mortality rate, poor nutrition, and susceptibility to natural disasters are also problems and a major concern for the people living in Nepal as well as the government (UN 2008, Health Profile accessed 2011). As a result of these concerns there have been massive political

movements and state-sponsored development projects that emphasize the creation and improvement of health services (Marasini 2003; Subedi; 1989; UN 2008, accessed 2011).

The urban health-care institutions and medicines are at a reasonable distance. The costly nature of allopathic medicine plays an important role for not consulting the allopathic medical practitioners. Bourdieu (1990) shows the issues in statistical terms that the amount of time and money which is spent on health caring and body cultivating activities vary significantly between different classes of people.

The government expenditure on health is generally low. Large number of people living in villages remains beyond the reach of this medical sector. When illnesses are minor, most people in rural area seek local healers because they are easily accessible and affordable. They are within their geographical and economic reach. In such areas, locally available healers and their medications are the only forms of cure that are within the economic access of people.

Transport and communication. Transport and communication play significant role in the choice of treatment options. It is associated with the location of hospitals / health centers and availability of doctors / medical persons. Maintaining a supply of drugs to remote health posts is a constant problem, as is keeping health posts and district hospitals staffed with trained, active practitioners (Justice 1986). But the Hyolmo region is just connected with rough road in 2011. Most of the villagers have access of electricity and means of communication, especially telephone and television. Small-scale hydroelectricity was produced from local *Phadung Khola* in 1986. Now it is stopped and the main line of national grid of electricity has been connected to this area. These changes have influenced their traditional medical practices. The Hyolmos who depended only on limited medical practices have been now diversified, and accordingly the tendency towards seeking modern western medicine is increasing gradually. (See detail in chapter vii)

Access to hospitals/ health centers. Traditional society, limited access to and unavailability of public health institutions, and low quality if available, high cost of allopathic medicine and modern health services also force most of the households to rely on home remedies. While access to the health post or hospitals has been easier than in the past (MoH 1997), home-based system of remedies were playing an important role in

health seeking behavior. For example, almost 90 percent of the childbirth in Nepal takes place at home rather than in such facilities (NESAC 1998). The rise and expansion of such institutions for enhancement in individual health status has changed in its structure.

There are a number of tendencies that are the characteristics of allopathic medical tradition in Nepal. The first tendency is that the locations of medical hospitals and research institutions, along with the allocation of resources are centralized in urban areas. The largest, most prestigious, most specialized and most money consuming curative institutions are located in the large urban centers (Streefland 1985; Subedi 2001).

The politicians and administrators who steer and take decisions regarding the health policy of the country stay in Kathmandu. Similarly, the drugs to be used are generally manufactured in the urban centers or in the rich countries. The ruling elites who are holding the power in the country collaborate with international agencies, foundations and bilateral aid program to determine health policies (Justice 1986).

Thus, the further the distance (physical or social) between the centre and the place where people reside, the more difficult it becomes to get good quality and sufficient quantity of medical supplies, facilities and staffs (Streefland 1985). The people of rural areas have not got proper health facilities due to the urban centered characteristics of hospital services, lack of proper decentralization of government health services and money-oriented private health services. As a result, they are compelled to go to the local service providers whichever available in their localities.

Urban orientation of modern health providers. Modern hospitals, health centers, clinics and manufacturers are based in urban areas. Their services are profit-oriented; thus they do not like to go to rural areas. It is difficult to find medical schools, libraries and research centers outside the larger towns. They do not focus their service to the lower social and economic strata. The politicians and administrators who steer and take decisions regarding the health policy of the country stay in Kathmandu. Similarly, the drugs to be used are generally manufactured in the urban centers or in the rich countries. The ruling elites who control the country collaborate with international agencies, foundations and bilateral aid program to determine health policies (Justice 1986).

As Subedi (2001) states, the tendency of the allopathic medicine is that in the developing countries like Nepal, this kind of medicine is capitalist and commercial in orientation. Many curative institutions, pharmaceutical companies and medical equipment industries are privately owned. The goal of many medical practitioners is to work privately and earn more money. Profit making is an important consideration in the delivery of health care facilities, and production and sale of drugs and materials. The consequence of such factors is that the best services and facilities are available in those places where people are living in a large number and where most wealth is concentrated. For the rural villages, it means relatively low numbers of drug sellers and relatively less qualified medical practitioners.

Culture and tradition. Medical systems are an integral part of all cultures, and it influences the health status of the person. Medical system includes the totality of health knowledge, beliefs, skills and practices of every group. It includes all clinical and non-clinical activities, the formal and informal institutions, and other activities that are even remotely connected with the ill-health of the community.

People's understanding of the bodily affliction and searching for cure is one of the most powerful forces in maintaining the continued acceptance of any medical tradition. The members of each cultural group have deep rooted beliefs that their own tradition must be useful if not the ideal system for handling the illness recognized by the culture. In Subedi's (2003) study, many informants said that allopathic medical practitioners have no curative treatment for illnesses caused by spirits and ancestors such as *bokshi*, *Ajima* and *lagu*. According to them, the *jharphuke* or *janne manchhe* do have such treatments. In particular, since the ill health is defined somehow differently from culture to culture, certain diseases appear repeatedly due to supernatural causes including *bhut/pret* and *bokshi,* and they are therefore recognized only by its own members. These types of understandings serve to reinforce the value of the particular medical tradition.

After patients consult a variety of healers with a range of remedial actions, their experience with the relative performances compel them to feel, perceive and value the ones from which they benefitted. If the dominant medical tradition is unable to provide adequately for the care of the population, other medical traditions fill these gaps.

Other associated factors. Besides the above-mentioned factors, there are other minor factors which play significant role while choosing health treatment component. Besides the knowledge and value perceived by healers and patients on physical, mental or spiritual concerns, healers' behaviors play the decisive roles, whether the patients seek them or not. Such patients like to go to the kind-hearted, smiling or cheerful and friendly healers who listen to their sufferings. Also, patients search for relatively expert, senior and experienced health professionals. And if the remedy reacted with harmful side or after effects, they seek other healers which could help them recover without such side effects or after effects.

Conclusion: Identification of Research Gaps

The main objective of this literature review is to explore the existing medical practices from the past to present in the medical pluralistic context, particularly focusing on ethno-medicine, and to investigate why the individuals of Hyolmo community choose the particular practices. This research also focuses on the changing pattern of health seeking behavior due to the various influencing factors and the perceptions of people towards different healers, including the healers' perceptions to each other.

The health-seeking process is the choice for all people all over the world. Humans have always been concerned about their ailments and have complex conceptions of life, death, sickness and treatments. Medical pluralism is a theoretical model that has been proven to represent most of the world's medical theories. It suggests that most cultures are host to several medical systems operating and existing in tandem. Medical traditions influence the choice of health care. The major medical practices associated with traditions are self-medication, indigenous medical practices, Ayurvedic, Homeopathic and allopathic medical traditions. Each system might be associated with a certain religious or ethnic group.

The literatures stress the diverse locales with heterogeneous and culturally complex population to study the phenomena of medical pluralism in which medical traditions are mixed. But my study focuses on the prevalence of medical pluralism even in a single locality that has homogenous culture with seemingly a single medical tradition.

From the literatures reviewed above, it is found that there is a general trend of shifting medical choices from traditional to modern in every society and group. But my focus is also on the choice of traditional healing, as healing is not a linear process. The patients might go to traditional healers even after they have attended the health center or hospital. Sometimes both the practices go side by side.

The next issue is concerned with the indication given by the literature that there is antagonist relation between the traditional and modern healing practices that exist almost everywhere. But there is complementary relation between the two practices. Modern treatment trainings have been launched in traditional communities for their *Dhami/Jhankris*. My focus is that combined medical practices are also possible and they may help each other in health issues. For example, *Dhami/Jhankris* can refer their clients to a health center or hospital after they do the primary treatment *(Jharfuk*).

In the case of Hyolmos, among the traditional healers, *Bhombo* is the familiar local healer somehow similar to *Dhami/Jhankris. Bhombos* are different from the general *Dhami/Jhankris* in their practices in *mantras* and procedure of healing. *Bhombos* use Tibetan *mantras*. Bhombos have both cooperative and antagonist relations to each other. Generally *Bhombos* of similar status have competition with each other, whereas they cooperate with a senior one, which the literature does not show. Also, almost every practice of Hyolmo is guided by the Tibetan culture including language, festival and medical beliefs. But the influence of Ayurvedic medicine observed in the community has not got been described in any literature.

Self-medication is one of the oldest practices basically understood as the use of medical substances without the consultation of medical person or professional. There is a lack of modern medicine in remote areas and they use local medicine. It incorporates both allopathic and home-made herbal medicine (more religious). The literature is inadequate to show the use of the medicine of both kinds as self-medication.

The literature shows that family and social status of person determine the health-seeking destination but it is not observed as the main factor in the people of tribal community. They use the same medical facilities or go to the same healers available in the local areas, whether they have a higher or lower status. It is due to the lack of their access in local areas as the hospitals are centralized in urban areas.

The above literature points out that there are some lacunas in this issue in the context of medical pluralism. Though it is not a recent phenomenon, every community and group uses different substances as medicine for various health problems so that it is always an issue for every researcher.

The available literatures are about other ethnic groups, and there are hardly a few literatures related to Hyolmos and almost no any literature about their medical practices, where the present research is focused. It also means that there is lack of anthropological studies on these issues and the community in which I am engaged.

CHAPTER III:
RESEARCH METHODOLOGY

This chapter presents the nature of the data, research design selected for the study, sampling procedure, process of data collection, and analysis. This is followed by the brief discussion on the data analysis process along with validity and reliability of the data. The issues of ethical considerations in qualitative research and the personal experiences of the fieldwork are also discussed.

The methodology of this study is the combination of qualitative and quantitative methods. Gage (1985) and Johnson (1976), as cited in Chhetri (1990), state that; anthropological research should involve a blending of quantitative and qualitative methods for data collection and analysis. Chhetri (1990) argues that a combination of qualitative and quantitative tools and technique at the data collection stage can provide a better body of data than by either of these alone. In this research, the qualitative tools and techniques such as interview, observation, case study and focus group discussion have been supplemented by quantitative tools and techniques like household census.

On the basis of the nature of this research, the study focuses more on qualitative method. Creswell (2009) states, qualitative research is a means for exploring and understanding the meaning individuals or groups ascribe to a social or human problem. As this research focuses to explore the existing health problem, healing practices and perception on healers and changes on practices the nature of this study is more qualitative.

The socio-demographic data gathered from survey definitely creates the foundation of answers of qualitative research questions but they do not fulfill the objectives of this research directly. Therefore my focus is obviously more on qualitative methods and tools.

Rationale for the Selection of the Study Area and People

This is a research on the plural medical practices among Hyolmos, one of the ethnic groups of the high hills of Nepal. This study tries to explore the peoples' knowledge and practices regarding ethno-medicine, plural medical practices and the behaviors related to treatment procedure along with social change.

Only a few researches have been carried out in the field of medical anthropology among the people living in high hills of Nepal. The study area of this research is Helambu, populated by Hyolmo people. Hyolmos of Helambu also have two distinct cultural categories in overall practices. The lower Helambu, including Timbu, has somehow modern culture due to the earlier connection with transport and communication for more than a decade. The upper part of Helambu like Melamchi Ghyang (study area) is not much influenced by outsiders' culture. They have unique indigenous medical beliefs and practices. Hyolmos have practiced plural medicine from the past. They did so even when they were was isolated from the outside world. Once anindependent and isolated village, the place is changing now and people are dependent on other communities and towns in economic, political and social aspects. The healing practices are also changing with these changes. Therefore, Helambu is one of the appropriate places for exploring plural medical practices and the transformation of those practices. So, to study the plural medical practices of non-Hindu minority group is interesting anthropologically. The study area was selected for research with this consideration.

Medical anthropology is still in the stage of infancy in Nepal and the related researches are limited. Helambu, the study area, is still virgin from the study point of view. The living condition of the villagers was entirely based on transhumant herding till four decades back. Now it is changing rapidly. To explore the existing reality about medical practices and medical pluralism with the recent changes due to the influence of outsiders' culture, this study has been undertaken among the Hyolmo.

Nature and Sources of Data

The information is based on both the primary and secondary sources. As it is an anthropological research, more focus has been given to primary sources of information. The primary sources of data were Hyolmo villagers. Some primary information was also gathered from non-Hyolmos who are residing in Melamchi Ghyang for decades as teachers and businessmen. Illustrations of the views and opinions of people are mainly based on the primary sources; and for the secondary sources, various literatures, profiles, reports and publications related to the Hyolmos have been reviewed.

Primary data have been gathered from the field using different qualitative research tools, mainly interview, observation, case study and focus group discussion; and

the necessary quantitative data were collected through census, which created the ground reality of the community regarding their perception and choice of medical practices. I argue that a combination of qualitative and quantitative tools and techniques can provide more information than the use of any one of the two.

The sources of secondary data consulted for this research were the various publications related to Hyolmos. The collection of secondary data began right from the pre-proposal phase and continued during the entire study period, till the last moment of finalizing the dissertation. Various necessary and relevant secondary sources have been utilized to triangulate the data collected from the field. They included published and unpublished documents available in libraries and personal collections. They were used to supplement and substantiate the primary data. Proper references have been cited whenever such data are used.

Universe and the Sampling Procedure

The universe of this study is the Hyolmo people of Melamchi Ghyang, Helembu, Sindhupalchok who claim themselves as an ethnic group, living in the high hill region of Nepal. There are a total of 96 Hyolmo households in Melamchi Ghyang, Helambu. Ethnographic census of those households was carried out to collect quantitative data related to socio-economic, demographic, educational and religious aspects in order to understand the existing medical practices.

Besides the census of households, a purposive sampling procedure was followed to select the key informants related to medical practices as the research is based more on qualitative data. Thakur (1997) urges that, in purposive sampling, one picks up the cases that are judged as typical on the basis of the needs of the researcher. I screened the potential persons as key informants from each health care provider and consumer with the purposive sampling strategy. I sought various categories of sex, age, education and economy for screening in order to maximize intra-cultural variation. Different key informants were selected from the health service providers and consumers purposively from the different sectors of healing from those 96 households, and they were interviewed intensively to seek the necessary information required for my research through purposive sampling. They include *Jhankris*, *Aamchi*, Lama (priest) and herbalists involved in traditional healing of the villagers for long, and nurses of local health post as

modern healers. They represented all sectors of healing. Local Hyolmos were selected from the local educated persons and social leaders as health service consumers, who could share the necessary information. And non-Hyolmos living in Melamchi Ghyang for decades for various purposes were also selected purposively as the key informants, and they were interviewed to know the outsiders' perspective on Hyolmos' medical practices. The non-Hyolmos were mainly the school teachers and businessmen residing there for long. The information gathered from non-Hyolmos helped to cross-check the information gathered from Hyolmos. Their information became more reliable to know the outsiders' views, who were also one of the agents of transformation in medical practices.

After the rapport building with the local community through long field work, brief focus group discussions with different local groups were held including different age, sex, education and socio-economic strata. It was conducted in the place where several people gathered such as teachers in school, participants in adult literacy class, people in Gumba, at the end of the meeting of mothers group and community forest users group. I utilized the situation where the people gathered for other purposes.

The events of healing at different contexts were taken for case study purposively. They were associated with self-medication, Lamaism, shamanism, *Aamchi*, herbal practice and a model of transhumant herding which has strong link with herbal collection. The informants were selected on the basis of the objectives of this research and the reference given by the local people.

Fieldwork

I went to the field in January 2013 for the first time and spent a couple of weeks for establishing the ground of fieldwork. In my first visit, I did the work of rapport building and got a general overview of people, geography and their culture, which guided me to prepare the questionnaire and interview guideline.

The field work was conducted mainly from December 2013 to January 2015. I stayed there from December 2013 to February 2014 continuously and in June and July, then in September and October of 2014. I did ethnographic census, key informants interview and focus group discussions within this period. As I was in the field, I could get chance to observe medical practices of *Jhankri*, *Aamchi*, herbal, self-medication, and allopathic practices, their different healing processes, and different rituals and cultural

practices. Those events became the information ground for my research. I lived in a house which is in the center of village near the Gumba and the health post. This was the appropriate location to observe the activities related to medical practices.

During my field stay in the months of June and July 2014, I gathered further information through key informant interviews, case studies and FGD. Some necessary but missing information was gathered in September and October 2014 between Dashain and Tihar, which is the leisure time for informants. Finally I visited the field once again and stayed for a couple of weeks in January 2015 at the time of Lhosar to gather additional information that were needed when I started to write the dissertation**.** In the study area, people who are the circular migrants to India are found in their village between Dashain and Lhosar. It is also their leisure time, so the necessary data could be gathered. In this way, I spent almost a year in the field to gather the information along with the frequent visits when I felt necessary.

Ethnographic Approach

Ethnography is a strategy of inquiry in which the researcher studies an intact cultural group in a natural setting over a prolonged period of time by collecting, primarily, observational and interview data (Creswell 2007). Such a study includes close observation and open ended interview. The description gives the characteristics of individuals, describes the facilities, and states the habits and attitudes of people towards medical practices.

Bernard says quite explicitly, (1989) “All ethnographies are subjective and selective. The object in social science is not to be devoid of an agenda. This is clearly impossible. The object is to maintain standards of data collection that eventuate in credible work. Anthropologists are enjoined to conduct research from a position of cultural relativism – that is, to avoid making judgments of the cultures we study" (p. 5). Showing the importance of ethnography, Walbridge and Sievert, (2003, p. 2) state, "Each way of life," we are told, "should be evaluated according to its own standards of right and wrong."

Explanatory Models of Kleinman (1978, 1980) are used in this research. The major advantage to use of this model is that it allows researchers to draw illness experiences from their participants in a structured way. The concept of this model has

been used in a variety researches in both the medical and public health fields. Researchers in the 1990s have also refined Kleinman's model into questionnaires that allows for clear analysis, such as the Explanatory Interview Catalogue, which Weiss and colleagues (1992) devised to student leprosy and mental health in India. Other uses include understanding HIV-related stigma, causes of youth violence, and perceptions of mental illness and diseases such as Type 2 diabetes.

Ethnography is a tool that could be used alone in qualitative research, or with other techniques such as life histories, key-informant interviews, participant-observations, focus group discussion or pile sorting, among others (Kleinman 1978). Medical ethnography of Hyolmos was carried out in this research. The following are the tools used for data collection under this ethnographic approach.

Household census. Census was conducted among all the 96 households of Melamchi Ghyang to know the socio-economic, educational and cultural background of the local people. It also explores the family structure, religious aspect, and health and hygiene aspects of the community. The census yielded information regarding the socio-cultural context of people for their treatment choices according to their family structure, economic well being, occupation, educational status, and the proximity of health services. Thus, this has provided a general pattern of multiple treatment options and treatment choices of the individual. Information related to why an individual goes to a particular health service provider was also collected through this census.

I wrote the questionnaire in English and translated into Nepali, taking care to frame the questions properly according to the language level of the local people. I myself administered the questionnaire because of the illiteracy of local people. Pre-testing of the questionnaire was done first on a small scale. Finally the census was compared with the report of Village Development Committee [VDC] profile.

I walked door to door with the help of local Pema Tashi Hyolmo, Kami Lama and Kamal Basnet, who helped me during census in the beginning, but in the later days I alone could go to every house because I was already familiar with the locals when my stay prolonged. A semi-structured questionnaire was utilized to carry out the census. The questionnaire is included in the Annex section.

Participant observation. Observation protocols are concerned with the result of a transformational process which is substituted for a meaningfully structured and contextually organized social event by means of *'post hoc'* typologizing, narrative, and interpretative representation (Bergmann 1985, p. 308, as cited by Flick, Kardorff & Steinke 2004). "If the observer observers by making himself, more or less, a member of the group, he is observing so that he can experience what the members of the group experience, the observation is called participant observation" (Kothari 2004, p. 96).

Observation is an important technique for data collection in anthropology. It is more important in qualitative research. Bronislaw Malinowski shifted the conception of ethnographers' role from that of inquirer to that of participant observer (Denzin & Lincoln 2005). Participant observation is grounded in the establishment of considerable rapport between the researcher and the host community and requiring the long term immersion of the researcher in the everyday life of the community.

I have used participant observation as a major tool for the collection of primary information in my research, and it was attempted wherever possible. I have examined the decision making process, behavior of health service providers, health service facilities, transportation facilities, healing process, healers' behavior, healers' performance etc. through participant observation. When I was in the field, I could get chance observe healing practices such as by *Jhankris* and *Aamchie*s, herbal, self-medication and allopathic practices, their different healing processes and different rituals and cultural practices. As an observer and participant observer where possible, I kept field notes throughout the period I spent in the field area and recorded the events I observed and participated in. The notebooks contain information on a number of issues related to the study.

Kleinman (1978) observed a gap between medical research and approaches to more practical solutions, and a mismatch between the physicians' understanding of disease and the patients' experiences of illness. To bridge this gap and to help clinicians break out of their medico-centric views**,** he proposed observation as a way to understand how patients view their conditions and their expectations or concepts of cure.

The local medical systems are the units of observation for anthropological field research. Because they are embedded in local communities, they vary from one part of

the world to another according to the family structure, religious, economic and political institutions of the regional and national societies in which they are located (Leslie 1980).

I got opportunities to observe many events in the field, including healing and ceremonial activities. I have maintained the observation of different medical practices in several times and situations; for example, *Jhankris'* attempt, *Aamchies'* healing, Lamas' practice, and self-medication practices of both homemade medicine and that of allopathy of local people, and the medical procedure carried out by health post. The descriptions of such events were obtained from the people who had participated in those activities. Observation guidelines had been used which helped to assess the real situation about the medical practices. It also helped to verify the information collected through the key informants' interview. As it is an anthropological research, intensive observation of different cultural practices of Hyolmo community was carried out through participant observation.

Observation can be of the setting or physical environment, social interactions, physical activities, non-verbal communications, planned and unplanned activities and interactions, and unobtrusive indicators (Best & Kahn 1996). I have carried out the observation of both planned and unplanned activities of different health service providers and consumers with the permission of both consumers and providers. It became possible only after I became familiar with the people and the community. Observations of the events and activities were out, and information obtained from other tools was triangulated with the facts of observation. I have narrated my personal experiences and observations in the analysis in chapters five, six and seven.

Key informant interview. In the qualitative research, the stories are collected of individual issues using a narrative approach. Individuals are interviewed at some length to determine how they have personally experienced the issues using open-ended questions (Creswell 2009). Explanatory models are elicited through a series of specific open-ended questions. The first model was devised by Kleinman (1978), which contains a number of qualitative questions. He came up with these questions in an attempt to distinguish between disease and illness and to bridge the gap between clinical knowledge and construction of clinical reality. I have also conducted interviews with the key

informants to gather qualitative information related to various healing practices historically along with their efficacy and people's perception about them.

As indicated in the explanatory model firstly I organized the questions and then obtained data through interviews and participant-observation, and then the interviews were transcribed. Findings are presented either on their own, as a collection of narratives on what research participants think of a specific topic, or paired with other quantitative data such as epidemiological information.

Interviews and life histories allow in-depth analysis of the lives of healers and patients, and medical discourse analysis is a specialized linguistic technique that studies the negotiation of meaning and power. Some specialists collect and analyze pharmacologic items; others study the history of medical practices (McElroy 1996). In-depth interview was designed to collect information from different key informants. The information sought from these interviews has been subjected for qualitative analysis.

Explanatory models can be administered either as an interview or through a questionnaire. Kleinman's model contains eight questions and also called eight-question model, which are useful to gather qualitative information. The questions include the expectation to get answers on various issues related to illnesses such as perception of patients about the causes of illness, causes of its beginning, its effect in the body, degree of seriousness, course of illness, idea about probable treatment, expected result of treatment, the main problem caused by sickness and the most fearful aspect of sickness felt by patients. The answer to these questions varies from individual to individual on the basis of their chances on medical choices. Therefore, I have applied his model to get the medical pluralistic reality of the field.

Semi-standardized or open interviews are widely used in social research. In the context of qualitative research, it is used predominantly in the preparation of standardized data collection and the development of tools. Qualitative interviews play an important role in ethnographic research project based on participant observation (Flick, Kardorff & Steinke 2004). Semi-structured interview was conducted to get in-depth information about the medical practices and their choices in Melamchi Ghyang. It provides important opportunities for an empirical application on medical practices and ideas. Ample information has been gathered using interviews. An interview guideline was made

comparing qualitative questions of Kleinman (1978), and research questions of this study have been used for the successful completion of key informants' interview. Questions were asked and the answers were recorded in a standardized form (see Annex 4).

Interviews were conducted wherever and whenever the occasion arose, mainly in the leisure time of the informants. It was conducted with all possible health service providers and socio-culturally forward consumers of both sexes who could explain the reasons of their medical choices. Some key informants were non-Hyolmos too and the information gathered from them made it possible to cross-check the information sought from Hyolmos.

Focus group discussion. Focus group discussion is the collective conversation or group interviews whether the group is small or large, directed or non-directed. It is popular tool of qualitative research. Explanatory Model used in this study is a method used in both clinical settings, and qualitative research as a way of obtaining individual explanations of a particular phenomenon (Kleinman 1978), which is gathered through focus group discussion.

Groups were formed including six to twelve people and discussions were held in the groups on medical practices and changes in them. Among the groups, one included male only, one female only and the rest included both male and female participants. The focus groups gathered in different appropriate places such as teachers in school on Friday after class; in public place after the meeting of forest users group; people taking rest in public Gumba; after the meeting of mothers' group; and at the end of adult literacy class. They were school teachers, mothers group, members of adult literacy class, and villagers at public place and Gumba. Among those groups teachers were both males and females and both Hyolmos and non-Hyolmos; people attending in literature classes were also both male and female Hyolmos. All the Hyolmo females were at mothers groups, and the villagers at public places were all male Hylomos. Those discussions also helped to find appropriate key informants.

A checklist for FGD given in Annex 3 was utilized to gather the qualitative information mainly about the informants' perceptions on health, sickness and illness. Discussions were made focusing on various dimensions of healing practices of the community. It also supported to gather the information on existing medical practices and

their causes of existence, their procedure and the fundamental changes in them. It supported to explore the existing plural medical practices and the reason of people's choice in some particular practice. Some important information was also noted down in the diary. It was carried out on the local's appropriate time.

Case study. Case study is a research strategy which focuses on a single organization, institution, event, decision policy or group (Baker 1994). Case study is useful in qualitative research and appropriate in medical anthropological study. Stake (1995) states, it is the inquiry in which the researcher explores in depth a program, event, activity, process of one or more individuals, where the detailed information is gathered.

Kleinman (1978) also used case study in his introduction to the explanatory model. He provided an interesting case study in a clinical setting.

> A 60-year-old Protestant grandmother who was hospitalized for heart problems exhibited 'bizarre' behavior during her recovery. She made herself vomit and wetted her bed frequently, but became angry when told to stop. When asked about her behavior, her explanation was revealing. As the wife and daughter of plumbers, the woman thought she had 'water in her lungs' and that the only way to clear the 'pipes' hooked to her lungs was to remove as much water as possible. Her induced vomiting and urination were part of this process, and she could not understand why people were angry with her. After this explanation, clinicians provided her with an alternate description of human anatomy and diagrams. When she understood her doctors, she stopped her earlier behavior. (p. 254)

Case study, a popular form of qualitative analysis, has been used on six different health service consumers by selecting purposively. Case studies have provided the complete information on health-seeking behavior and their changing pattern. It has also helped for the generalization of this research. I have done case study on Lama, *Jhankris*, self-medication practice, herbal practice and *Aamchi* as the various healing alternatives. To know the changing pattern in culture, especially in medical practices, I have also carried out case studies on the life style of peoples living in cow and yak sheds as the examples of transhumant herding, which is one of the major sources of herb collection. A checklist for case study was made and utilized (see Annex 5). The events were recorded using recorder and also noted down in diary.

Reliability and Validity of Data

The questionnaire that yields consistent responses when asked multiple times is called reliability. Reliability refers to the consistency of score or answers from one administration of an instrument and from one set of items to another (Jack & Norman, 2006). Similarly, questionnaire that gets accurate responses from respondents is validity. The most important criterion of research is validity. It is concerned with the accuracy of the conclusions that are generated from research.

This research is entirely based on fieldwork and primary data to get firsthand information as it is an anthropological work. This is qualitative and quantitative research with a greater focus on qualitative dimension. It argues that the qualitative research has 'its own procedures for attaining validity that are simply different from those of quantitative approaches' (Maxwell, 1992).

The sources of primary data are the local Hyolmos. Participant observation, a popular technique in anthropology, has been used in this research. Alder and Alder (1994, p. 383) suggest that observational research is found as a part of methodological spectrum, whereby observation is done as the most powerful source of validation'. Qualitative validity means that the researcher checks for the accuracy of the finding by employing certain procedures, while qualitative reliability indicates that the researcher's approach is consistent across different researchers and different projects (Gibbs, 2007). The information is gathered by researcher himself. The verification of the information obtained at every stage of data collection is consistently maintained. It is done by the process of verification and confirmation.

It is believed that observation validates the gathered data, maximizes the efficacy, minimizes the investigator's bias and increases the reliability of data (Gold, 1997; p. 397). As it is an anthropological work, observation was used as a main tool of data collection. Fieldwork itself is a foundation of validity. Participant observation, as a data collection tool, validates the research in anthropology. For this I introduced myself with my aim to be there by clarifying the purpose of study and use of data. I became familiar with the community through participation in their activities in different events. The narratives obtained have also been cross-checked and verified by repeating the same questions to the same respondents in some time gap.

The collected data from census and interview was cross-checked by observation and case study. The questionnaire for household census was tested in the field as pilot test to get the accuracy of information, and the necessary questions were added for census. The triangulation of both qualitative and quantitative data has made the study further reliable**.** Thick ethnographic description is made in this report, which has made the result more realistic and richer. Researcher's opinions are justified with the informants' narratives which clarify that the report is free from prejudice.

The necessary data had been collected mainly in winter season so that the respondents had sufficient free time to interact and, even the ones who had gone out, (different places of India and Kathmandu) had returned home for their main festival, Lhosar**.** I have conducted long field work for building rapport with them.

The informants were very cooperative. I controlled the interview by providing the appropriate verbal and non-verbal feedback.

Data Processing and Analysis

Processing implies editing, coding, classification and tabulation of the collected data so that they are amenable to analysis (Kothari, 2004). The process of data analysis involves making sense out of text through preparing the data for analysis, conduction different analysis, moving deeper and deeper into understanding the data, representing the data and making an interpretation of the larger meaning of data (Creswell.2009).

First, the collected raw information from the interviews, information from FGD and field notes were organized and transcribed for the preparation of their analysis. Second, they were categorized into different themes on the basis of the sources of information as well as research questions. Then all the data were read carefully to obtain their meaning and then notes were written in the margins.

The collected data were edited immediately in the field and later again after the fieldwork. It clarifies the accuracy, consistency, and uniformity of data. It also guides to collect complete information. The edited data were codified by segmenting sentences into categories or themes and labelled those categories with certain term for effective analysis. The data were reduced to a smaller number of classes for several replies. Then the necessary information was classified on the basis of their common characteristics. Such a classification created homogeneous groups of raw data. Then the data were arranged in

order in certain rows and columns for tabulation. It helps for comparison, analysis and generalization.

Findings or textual data from explanatory model interviews can be analyzed in various ways. In two studies that used explanatory models as the main tool, researchers (Biering, 2007; May & Rew, 2010) first organized their questions and then obtained data through group interviews and from participant-observation. Then the interviews were transcribed. I have also organized the open ended questions and interviewed individually to the key informants and compared the information got through participant observation.

All the data, information and opinions gathered from both primary and secondary sources were processed, analyzed and interpreted to prepare this report in the form of dissertation. The study is mainly of qualitative type, so mostly descriptive design was used. For the analysis of qualitative data, I put my consistent effort and attempted to gain a deeper understanding of my observations and narratives. Analysis and interpretations were made continuously throughout the study period. The analysis began right from the time of information collection.

After data processing, the second phase of analysis was carried out. The quantitative data gathered from census were analyzed using simple statistical tools such as percentage, mean, range etc. Quantitative data provides the clear picture of social, economic, cultural, political and educational aspects which influence to determine the medical choices. It has further justified the qualitative facts. While making an interpretation of qualitative data, a comparison of finding with literatures and theory was made this confirms past information in one hand and suggests new questions for the study.

I created a number of variables guided by the literatures about what medical practices the Hyolmos follow and what factors have played significant role in the change of their medical practices. For this, plural medical practices are taken as dependent variables and the factors influencing the changes in medical practices such as socio-cultural, economic, and educational factors are taken as independent variables in this research as demonstrated in the conceptual framework.

Qualitative methods include three kinds of data collection: in-depth, open ended interview; direct observation and written documents. Each of the three kinds of data

analysis involves various activities such as direct quotations about the experiences of people, opinions, feelings, knowledge, people's behaviors, actions, interpersonal interactions, organizational processes, experts' quotation from documents, program records, memoranda and correspondence, personals diaries and open ended writes responses to questionnaires and surveys (Patton 1990). As this is an ethnographic research, it involves a detailed description of the setting or individuals followed by analysis of data for theme or issues (Stake 1995). In this research, the information was gathered from interview, observation, FGD and case studies and analyzed. The existing medical practices, perception of people on different healers and factors contributing to the change were analyzed in qualitative terms which were supported by quantitative data collected through census that created the ground reality to answer the research questions. The socio-demographic data gathered through census were analyzed using simple SPSS tools.

Ethical Considerations

According to Cohen, Manion and Morrison (2002), "The researcher should be careful about the respect, confidentiality and informed consents of the participants" (pp. 8-9). Ethical issue in anthropological research is an important issue. The issue is further serious in medical field in the aspect of privacy. Generally people do not like to share the condition of their health and illness as it is too personal issue. They hesitate to answer in the fear of the loss of their secrecy. Therefore, I have maintained a strong ethic on consent, confidentiality, privacy and reciprocity in this research. While conducting this research, I have followed all the norms and guidelines of research ethics which administering the questionnaires among the informants.

Before conducting the interview with the key informants, prior consent was sought from them in the respectable manner. I received their permission to continue the interview with the understanding that I would keep their information confidential. I tried to gain confidentiality but never tried to influence the informants to get information. To take photographs and recording their narration too, prior consent was taken. While writing the report, I judged and avoided the sentimental information which might produce adverse effects as it becomes the public property after its publication.

I always introduced myself as a Ph. D. candidate enrolled in Tribhuvan University, and clarified the objective of data collection and their use. When the informants shared the totally personal and sentimental information, I would ask them if I could use the information in my dissertation. I never misinterpreted their information consciously throughout the research process till the writing of the final draft.

I have used pseudonyms for some narrators and informants where I felt necessary to protect their privacy, but the real name is given in many cases. Pseudonyms were given to those informants who were interested to share the information but did not want to reveal their names.

No incentive was provided for getting answer. Instead, the respondents were quite autonomous and enthusiastic to share their information and experiences. I have carefully avoided the fallacious matter during the focus group discussion. When I lived in the village for long field work, I stayed there as a paying guest and did not give any economic burden to the villagers. I paid myself in teashop when I conducted discussions.

I asked the necessary question for research in a discussion form with the participation of the locals, instead of asking questions to them rapidly one after another. I listened to them as long as they expressed their view even if their information was not useful for me directly. If anybody wanted to listen to me, I gave plenty of time to clarify the issues. When someone asked me to share my experience about different medical practices, I shared the ideas what I knew. As I carried out census in the village, they were keen to have an updated report, which I gave it; this was a way of mutual sharing of the information.

Limitations of the Study

This study is carried out about different healing practices, causes of peoples' choice and the different factors contributing to the change in medical practices in a particular place and time. Hence this ethnographic study has its significances as well as limitations. There is always the question on the consistency of findings due to the time change. It also brings changes on healers and consumers relation and their perception to each other.

This qualitative and quantitative study on plural medical practices was carried out in Melamchi Ghyang of Hyolmo region, Helambu VDC-6, Sindupalchok, the mid hills of

central Nepal. It may not be applicable to the Hyolmos residing in other part of the country.

The medical beliefs and practices of the Hyolmos of Melamchi Ghyang have only been explored in this research. I have used 'Explanatory Model' as a theory to explore the qualitative aspect of medical behavior of the people in the study area. Theoretically, the limitations of the model which I used is also the limitation this study and the study is also limited to the prescribed data collection techniques and research design as described previously (In chapter three). Most of the data generated through qualitative approach is itself the limitation of this study.

Personal Experiences of the Fieldwork

The place was new to me, and I arrived at midday as I had heard that there was accommodation problem for native (Nepali) people. First I kept friendly relationship with school teachers. I went to the local school first and asked the head teacher for help. He showed some hotels suitable for me. I went to the hotel but the owner denied me a room. I searched the next hotel, and I got success in the second attempt. The next day, the head teacher asked me surprisingly how I got the room and he clearly stated that I might have got the chance of accommodation because of my personality. It was true that they usually provided room for natives only after looking at the personality (personality here means the outlook which reflects the economic capacity). There were mainly two reasons for not giving room for natives: one was they prioritized foreigners, who pay a high rate for accommodation, and the next reason was Nepali people were blamed for not maintaining their personal hygiene.

As I was an outsider, the villagers at first were suspicious of me and my motives. The information obtained was heavily influenced by villagers' perceptions of me. Initially they were unreliable sources of information due to their suspicion, and initial data were just partially true. Therefore, the conversation was limited to their culture, tradition and weather in the initial days. I spent plenty of time to clarify the purpose of my study and to introduce myself. Gradually I won their confidence and they gave their information more freely.

In the later days, as the time passed, the villagers became interested in my work and began to fulfill my queries. They became largely helpful to gather qualitative data. I

became familiar and I was welcomed in many houses even in the time of Lhosar festival. Many Hyolmos and non-Hyolmos supported me during the field work.

I felt language problem as I was not able to carry on even ordinary conversation and to comprehend much of what was being said by informants. In the later days, when I became familiar with the community people and their basic language like *Tashi Delek* (Greeting), they offered a warm hospitality. Mainly, household women who could hardly speak Nepali language asked me, "*K khanu hunchha sir?" (*What do you want to eat?) I used to reply, "*Je bhaye pani hunchha*." (Anything you give is ok for me). I wanted to be the easy guest, and they will not feel any burden for me. This answer was repeated to any households wherever they wanted to offer anything for me. They laughed when I replied. It took time to find the reason of their laughter and finally I found it. The meaning of *'Je'* in Hyolmo language is female reproductive organ.

CHAPTER IV:

THE SETTING: THE PEOPLE AND THE PLACE

This chapter provides the general information of the study area and the people. The information was collected through census and other data collection techniques. Besides, some secondary data from CBS and other sources have also been used. This chapter presents the socio-economic, demographic, educational, cultural and historical background of the people and the area, which were quite useful to know the dimensions of plural healing and medical practices.

The chapter begins with the general introduction of Sindhupalchok and then a brief introduction to the study area. It clarifies the position of Helambu and Hyolmos in the district. It also portrays the situation of study area and people to know why and how they are involved in different medical and healing practices when they suffer from illness.

Sindhupalchok: An Overview

Sindhupalchok is one of the 19 districts of Central Development Region and one of the 8 districts of Bagmati zone. It lies between the 85.27' to 86'07' east longitude and between the 27.27' to 28.13' north latitude. There are 3 constituency areas, 13 *ilakas*, two recently established municipalities, (Chautara declared on 25th Baisakh 2071 and Melamchi declared in Mangsir 2071), and 68 Village Development Committees in the district. Earlier, there were 79 VDCs but no municipality in the district. This district was recognized as 'East Number One' combined with the present Kabhrepalanchok; and the district headquarters then was at Kabhrepalanchok till 2018 B.S. Sindhupalchok got independent identity as a district in 2018 BS when Nepal was restructured into 14 zones and 75 districts. The total area of the district is 2542 sq. km. Its district headquarter is Chautara.

Sindlupulchok is the district named after two famous hills, Sindhu and Palchok. Palchok is also famous by the goddess Bhagawati. It is situated to the northeast of Kathmandu. Geographically, this district is surrounded by Rasuwa, Nuwakot, Kathmandu, Bhaktapur, Kabhrepalanchok, Ramechhap and Dolakha. Its northern border is joined with Tibet, the autonomous state of China.

***Figure 2*. Map of Nepal Showing Sindhupalchok District**

The district is famous for different tourist areas such as Helambu, Panch Pokhari, Tatopani, Mt. Jugal (the nearest mountain from capital city, Kathmandu), Bhairab Kunda, Patal Kunda, Mudhe, Bhotechaur etc. Helambu trekking route was opened four decades ago. The district has become famous by Palchok Bhagawati, Gaurati Bhimsen and many Gumbas located at different places of the district. It is connected by Araniko Highway, Helambu Highway and Pushpalal Highway besides the agricultural ungravelled roads. Now the district is recognized by Melamchi Drinking Water Project, one of the mega water supply projects of Nepal.

There are different castes/ethnic groups living in different part of the district. They are mainly Brahmin, Chhetri, Tamang, Sherpa, Hyolmo, Newar, Majhi, Danuwar, Magar, Gurung, Kami, Damai, Sarki, etc. The ethnic groups have their own mother tongue, but they use Nepali as lingua franca. They all have their own distinct cultural practices. Medical practice also differs on the basis of caste, ethnicity, education, and facilities.

The demographic feature of the district is compared in the Table 2.

Table 2: ***Population of Sindlupulchok***

CBS	Male	Female	Total	Average size of family	Average population density	No of households
1991	131523	129502	261025	5.1	102.7	51291
2001	152012	153845	305857	5.06	120.32	60452
2011	138351	149447	287798	4.32	113.22	66688

CBS (1991, 2001, 2011)

The latest census (2011) has shown the decreasing trend in population and family size compared to the 2001 census. The population of male seems higher in CBS 1991, while that of female is higher in 2001 and 2011. The total population also seems decreasing in 2011 census, along with decrease of average population density but the number of households is in increasing order in every census.

Introduction to Helambu and the Hyolmos

Helambu is situated in the north-west of Sindhupalchok, the high hill of central Nepal. It is situated at the height of 1370 to 3302 meters above the sea level

Helambu is one of the 68 VDCs of Sindhupalchok. It is situated in the north-western part of the district. Tibetan migrant Buddhist Hyolmos live in this region. Helambu is derived from the word 'Hyolmo', in which 'Hyol' means the place surrounded by mountain and 'Mo' means goddess or mother. In Tibetan, Yolmo means "place screened by snow mountains/glaciers" (Clark 1980b) and refers to the wall of 5,000-meter peak that forms the northern boundaries, separating Yolmo from the Langtang valley to the north (Bishop 1998).

Melamchi Ghyang was a village located at the altitude of 2,565 meters below the present settlement. Old respondents remember those days but there is no settlement now. The present settlement of Melamchi Ghyang is at the altitude of 2,600 meters. Helambu is the third biggest VDC of the district having the area of the 185.5 sq. km.

Melamchi Ghyang, a village of Helambu, is in the northern most part of the VDC adjoining VDCs of Rasuwa and Nuwakot districts. There is Rasuwa in the north and Nuwakot district in the north-west. Baruwa VDC of Sindhupalchok is to the east and Ichok and Kieul VDCs of the district to the south of Helambu. Melamchi Ghyang is on the lap of the mountain just below the forest area of Langtang National Park.

***Figure* 3. Map of Sindhupalchok District Showing the Study Village**

The local informants also shared the ideas about the name 'Helambu' in different ways. They shared that 'hey' means potato and 'Labu' means radish in Hyolmo language. It is the place where plenty of radish and potato are grown.

Various aspects of the study area are briefly discussed below.

Physiographic aspect. Geographically, the latitude of Helambu is 27.43' north to 27.46' north and the longitude is 85.32' 30" east to 85.34'30" east. It is bounded by Kieul and Baruwa VDC to the east, Ghyangphedi and Gaukharka VDC (Nuwakot) to the west, Langtang VDC (Rasuwa) to the North and Ichock VDC (Sindhupalchok) to the south. Hyolmo region is not limited to the only Helambu VDC. It is bounded by Indrawati River to the east and Thare Danda to the west. Thare Danda is a mountain spur that drops south from the alpine lake at Gosainkunda to the last Hyolmo village of Golphu Bhanjyang.

Helambu is about 70 km northwest from district headquarters Chautara and about 100 km northeast from the capital, Kathmandu.

Topographically, Helambu is a high hill area in which the altitude decreases gradually from north to south. Mt. Yangrima (3,660 meters) is situated in the northernmost part. The cluster of settlement is found in the southern part. There is Melamchi River as the main river that crosses the VDC. The river is the uppermost branch of the Indrawati River, one of the tributaries of Sapta Koshi River. There are other seven rivulets in the VDC named Chokpu, Nakote, Kharchung, Sarkathali, Fadung, Ribarma and Timbu, which flow to Melamchi River. These rivers and rivulets irrigate the lower land (*besi*) of this VDC. Malamchi Ghyang village is a small *tar* (plateau) situated in the northernmost part of the VDC.

The region generally experiences a temperate climate. The climate varies in different parts of Helambu as its altitude differs from 1370 in to 3302 m. The lower part of Helambu like Timbu, Kharchung, Doring, and Nakote experience 24^{o} C to 30^{o} C temperature in summer and up to 0^{o} C in winter. The settlements like Melamchi Ghyang, Tarke Ghyang, Ghyangul, and Sermathang experience 15^{o} C to 20^{o} C temperature in summer and up to -5^{o} C temperature in winter. The general temperature in winter seldom falls below 0^{o} C and the snow falls in its upper parts. Due to the cold climate, people are generally healthy, but they are caught by some health problems caused by cold, mainly in winter.

Langtang National Park, the second biggest national park of Nepal on the basis of area, occupies 57 percent of its land in Rasuwa, 7 percent in Nuwakot and 36 percent in Sindhupalchok. Its total area is 1710 sq. km. Some parts of the park lie in Helambu, which is the store house of various species of flora and fauna. Due to the availability of medical herbs, the practice of herbal treatment is common among the locals.

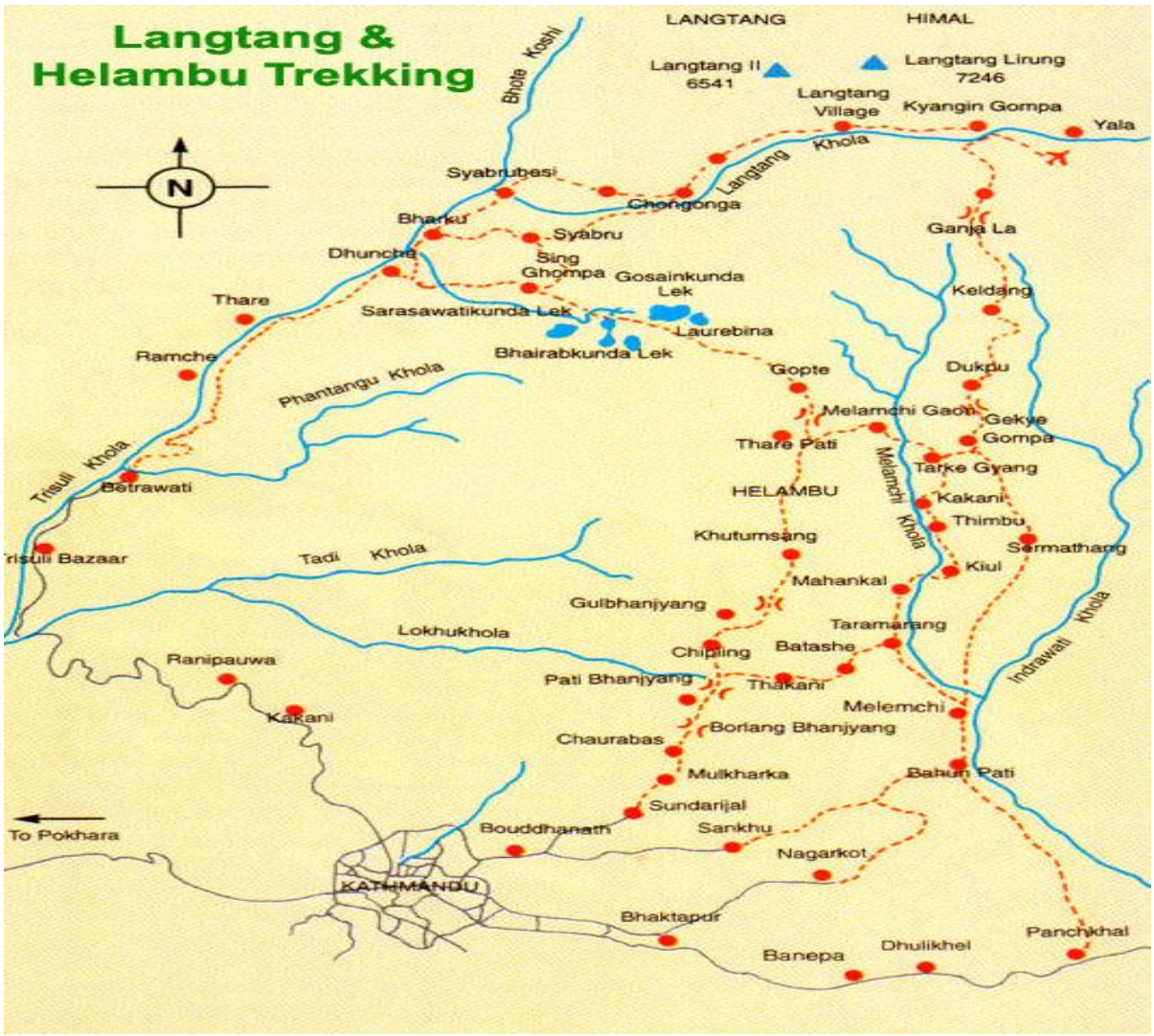

Figure 4. Route of Melamchi Ghyang

Fortunately, for Melamchi, the local environment promotes good health through good water resources, sparse population in the village, an altitude and climate that precludes tropical diseases such as malaria, and a diet of dairy products and grain (Bishop 1998).

Historical aspect. Though Nepal is geographically a small country, there are many caste/ethnic people residing in different parts of the country from the remote past. Mainly there are Caucasoid and Mongoloid people of Tibeto-Burman ethnic group. According to the censuses of 1991, 2001 and 2011, altogether 61, 103 and 126 ethnic groups have been recorded respectively in Nepal. Hyolmo has been enlisted as one of the 59 an indigenous groups in Nepal in 2056 BS.

Hyolmos are the people who reside in Sindhupalchok, Nuwakot, Dhading, Ramechhap, Gorkha, Chitwan and Darjeeling, but their main residence is Hyolmo region of Sindhupalchok. Helambu, the motherland of Hyolmos, is situated on the lap of Himalaya, the northwest of the district. Hyolmos are the ethnic groups who have distinct culture, tradition, religion and rituals. They are professedly Buddhists.

Hyolmos were socially marginalized people due to the state's discriminatory policy in the past. They had no right to join in the army, police or other government jobs till the Rana period. They disguised their identity by changing their surname such as to Gurung to grab those opportunities (Lama 2057 BS). Therefore, it is not easy to find the actual historical aspect of Hyolmo. An informant shared, "The low land people (*Rongwa*) call high land people as Lama. While making citizenship card, only the person's first name was asked and the office clerk wrote 'Lama' as surname automatically, and then our surname became Lama. Actually we are Hyolmo Sherpa."

Hyolmo region is believed to be a holy land. The word Hyolmo sometimes comes in a combined term Nechen-Beyul-Hyolmo, in which Nechen means religious place and Beyul means place of hidden treasure. Etymologically, Hyolmo is the combination of 'Hyol', which means the place surrounded by mountain, and 'Mo', which means goddess. Thus, Hyolmo means the area nearby goddess Yangri surrounded by mountains.

The story told by Lama Tenjing Hyolmo, the respected Lama of Melamchi Ghyang, about the earlier history of Hyolmo region on the basis of 'Explanation of Rimpoche' is as follows:

> Guru Rimpoche meditated in the 8th century in Hyolmo region and went to Tibet. He informed the Tibetans that Hyolmo region has hidden treasure of knowledge and it is a holy place. Then Tibetans entered in this region through the way of Kyirong and started to settle here. Rimpoche gave the name Hyolmo to this region. This is not Helambu region. Actually it is Hyolmo region named by Guru Rimpoche. It expands in a wide area. Hyolmo was converted into Helambu recently. The name of Helambu VDC was Timbu Ghyangul VDC previously and was changed recently to Helambu. Therefore Hyolmo was its original name and the old name of Melamchi was Milimchhim.

Hyolmo people were known as Sherpas or Helambu Sherpas in the late 1960s. Previously they called themselves Lama People to distinguish themselves ethnically from Tamang clan who neighbored them on the southern and western sides of Yolmo region (Desjarlais 2003). Yolmos claim that their ancestors have lived for three centuries or so long in the upper, forested ridges of the Yolmo Valley (Clark 1980 a; Bishop 1998; Desjarlais 1992). At least some of these ancestors were Buddhist priests, known as Lamas, who migrated from Kyirong, an area in the southwest of the present day Tibet, to the central upland area of Yolmo after receiving land grant from Buddhist temples bestowed to them by Newar and then Gurkha kings (Clark 1980 b).

The present day Hyolmos were called Sherpas to refer to the Sherpa of Solu Khumbu region in around 1950 when Solu Sherpas got a high respect and fortune by mountaineering expeditions. This lends support to the view that the Lama people wish to associate themselves with the relative respectability and power of the Sherpas of Solu Khumbu and to disassociate themselves from the Tamang people, who cannot refer to themselves as Lama, but whom the Lama people of Helambu regard as being lower in status than themselves (Clarke 1980 c).

At the local election conducted by state officials from the district headquarters Chautara in 1976, the people were present at Tarkeghyang (village east to Melamchi Ghyang) for the election, and all of them referred to themselves as Sherpas to these outsiders (Clarke 1980 c). In this way, the Lamas of Helambu were changed into Sherpa to show their higher status during the 1950s and 60s, but recent national movement of social inclusion after people's movement 2062/63 turned them into the identity of Hyolmo. Now everyone in this community residing in Helambu claims themselves as Hyolmos.

Demographic aspect. According to CBS 2001, the total population of Hyolmo was 579, with 281 males and 298 females. It implies that all Hyolmos did not identify themselves as Hyolmo and their number is one of the least. CBS 2011 showed their number to be 10,752, with 5,115 males and 5,637 females. But the Hyolmos claim that their number is more than 50,000 and are scattered in 12 districts of Nepal and Darjeeling and Sikkim of India.

The majority of people in Helambu are Hyolmos. Table 3 shows the population structure and households of Helambu VDC.

Table 3: ***Population Structure of Helambu VDC***

CBS	Male	Female	Total	Average family Size	Pop. Density	No. of HHs
2001	1344	1335	2679	4.55	14.44	589
2011	1258	1306	2564	3.91	13.82	656

Source: CBS (2001, 2011)

The total population of Helambu according to CBS 2001 is 2679 in which male number is 1344 and female number is 1335; and according to CBS 2011, the total population is 2564 with the male number 1258 and female number 1306. The total population seemed to have decreased by 115 (4.3 percent) in the recent CBS. The family size also decreased from 4.55 to 3.91 on the respective CBS, so did the population density, from 14.44 in CBS 2001 to 13.82 in CBS 2011; but the number of households (HH) seems increased from 589 to 656 between the two censuses.

When talking about the households in Melamchi Ghyang, Bishop (1998) states that there were 35 households in 1971/72. The number increased to 78 in 1986. Similarly, there were 91 in 1989 and 100 households in 1993. But I found only 96 households in 2014 in my census. This finding of less number of household than two decades ago is very interesting. The reason I found is the permanent migration of Hyolmos to Kathmandu, mainly in Bouddha area. Fifty percent of them have home in Kathmandu and reside in Melamchi Ghyang seasonally.

This study was carried out in Melamchi Ghyang, situated in the upper high hill of the northern part of Helambu VDC-6. There were a total of 96 households and 534 people in Melamchi Ghyang. The age and sex composition of the population is shown in Table 4.

Table 4: ***Age Structure and Sex Composition of the Population***

Age Categories	Population			Percentage
	Male	Female	Total	
Less than 1 year	6	7	13	2.43
1- 5 year	14	18	32	5.99
6-14 year	36	32	68	12.73
15-59 year	183	172	355	66.48
60 years and above	32	34	66	12.36
Total	271	263	534	100

Source: Fieldwork, 2014

According to age-wise distribution of population, about 21.15 percent people are below the age of 15 years, and 66.48 percent of the population falls under the category of economically active population, i.e. the age between 15 to 59 years. Similarly, 12.36 percent of the population in Melamchi Ghyang is 60 years and above. This age group is the economically dependent population; however, the young population below 15 years is also dependent.The table shows that the population of males is slightly greater than that of females, which is just opposite to the national ratio.

The above data do not match with the data of current national census. In this data, the percentage of the population of the age 0-14 is lesser and the population above 60 years is slightly more in comparision with the current national demographic profile (2014). The lesser percentage of children may be due to the low birth rate and foreign employment of youths. Regarding the old people, cold and healthy environment might have increased. However it needs to be explored since I am less concerned in demographic figure, I have not gone through it.

Educational aspect. There are altogether 8 schools in Helambu VDC. Out of 8 schools, 2 are high schools, 1 is lower secondary and 5 are primary schools; but there is no private boarding school. Schools are not equally equipped in terms of infrastructure, educational materials and library and teachers.

Before the establishment of schools, some locals had received non-formal education from Gumba, to become Lama (Hyolmo priest). Some children study only *Lama Bidhya* (Buddhist education) even today and do not enroll in school.

The first school of Helambu region is Gorakh Nath Primary School, Tarkeghyang, which was established in 2017 B.S. It started to educate the people in this region. Melamchi Ghyang Secondary School situated in the study area is one of the best schools of the district in terms of SLC results. The students from other areas of the district and even from Kathmandu study there in hostels. According to school records, there are 255 students studying there with 92 boys and 136 girls. This school also has run the class up to 12 in collaboration with Saraswoti Higher Secondary School, Gyalthum, situated in the low land some 15 km below. Despite the establishment of school and running adult literacy classes, the literacy rate is still low compared to the national level literacy rate. Some school-aged children are illiterate or have dropped out because of their parents' seasonal work in India. Many parents stay there only about three months of the festival season (around Lhosar).

Table 5 presents data on the educational status of the people of Mealmchi Ghyang.

Table 5: ***Literacy Status of the Population Aged above Six Years***

Educational status	No. of Male	%	No. of Female	%	Total Population	%
Average literacy rate	**187**	**74.5**	**116**	**48.74**	**303**	**61.96**
Illiterate	64	25.5	122	51.26	186	38.03
Literate	147	58.57	79	33.19	226	46.21
SLC	15	5.98	25	10.50	40	8.18
Intermediate	19	7.57	12	5.04	31	6.34
Bachelor's	5	2.0	0	0	5	1.02
Master's	1	0.4	0	0	1	0.20
Total	251	100	238	100	489	100

Source: Fieldwork 2014

Table 5 shows that about 62 percent people above 6 years are literate, i.e. only 38.03 percent are illiterate. It depicts that 74.5 percent male are literate and 25.5 percent are illiterate. Despite the female literacy classes run by *Aama Samuha* (mothers groups) continuously for 5 years, female literacy rate is only 48.74 percent, which means still

51.26 percent females are illiterate. Despite the high school facility in the locality, 5.98 percent males and 10.50 percent females have passed up to SLC level. The data shows that 7.57 percent males and 5.04 percent females have passed higher secondary (+2) levels. Only 5 males have passed bachelors and a single male has passed master's level, that no female has passed the bachelor's level. Among the educated, two are studying JTA and a single male has just completed MBBS.

Economic aspect. Economy plays an important role in medical choices. It is impossible to locate the health behavior without knowing the economic status of the people. The main economic aspects are discussed below.

***Agriculture*.** Agriculture is the secondary occupation (or alternative to herding) of the people of Melamchi Ghyang. A combined system of animal herding and agriculture is called *goth* system which is found in groups living in lower altitude. Animal dung is used as manure for better agro-production, and surplus agro-products are fed to animals. But surplus production is rare because there is very little agricultural land. No land has irrigation facility in the study area. Water sources are found in the gullies between the spines but these are usually too steep to terrace. There are no rice fields; there are dry lands in the village. People produce potato, radish, green vegetables, barley, maize, wheat, etc., in the dry field with the help of monsoon rain. Helambu was famous for apples in the past, but it has not been produced properly for more than two decades. A local social leader claims that apple production was abandoned due to lack of technical knowledge about its production. There are apple trees but there can be no production because of diseases and insects. The people were found having no idea of modern agriculture; nor do they have the idea about insecticides and pesticides. Peach is the next fruit found in Melamchi Ghyang.

About 94 percent people have their own land (*Raikar*) and 6 percent have land under *guthi* of Chiniya Lama. The process of changing the land of '*Guthi*' into *'Raikar'* is still continuing. Local elders shared that Chiniya Lama was the priest (Lama) of Boudha Ghyang, Kathmandu, who was a powerful person having link with the royal family. He registered Melamchi Ghyang as his personal Guthi and captured it. Chiniya Lama also changed the name of local Gumba to Urgen Chhyoling Chiniya Lama Gumba; earlier its name was Gonpo Hopame Kye Lhakhang Gumba. All the land of Melamchi Ghyang was

under *Guthi* till a decade ago. Damai Lama, a local old respondent, said, "The Lamas of Melamchi Ghyang could not pay the land tax which was paid by Chiniya Lama and the land became *Guthi* of Chiniya Lama in the past".

Table 6: ***Distribution of Households by their Size of Landholding***

Land Area in Ropani	No. of HHs	Percentage
Less than 5 Ropani	33	34.37
5-10 Ropani	60	62.5
10-15 Ropani	3	3.12
Total	96	100

Source: Fieldwork, 2014

Table 6 shows that all the households have less or more land, either *Guthi* or *Raikar*. About one third (34.37 percent) of locals have the land less than 5 Ropanis, and more local people (62.5 percent) have the land between 5 to 10 Ropanis. Only 3 households were found to have land above 10 Ropanis, who also have additional land (*khet*) on the basin of other VDCs.

The production of their field is used where it is necessary: 93.75 percent respondents informed that the agro production was used for livelihood, 81.25 percent said the production was to use for festivals and 18.75 percent shared that their production was used for selling (see Annex Table 1). Generally they sell potato and radish in hotels in the market below the village. They also exchange them with grains with the farmers of next village. They sell the vegetables in the hostel of Melamchi Ghyang School. The percentage exceeds more than 100 due to the multiple responses of using production.

Table 7: ***Distribution of Households by their Food Sufficiency***

Survival period	Households	Percentage
Up to 3 months	25	26.04
3 to 6 months	40	41.66
6 to 9 months	13	13.54
For whole year	18	18.75
Total	96	100

Source: Fieldwork, 2014

Table 7 shows that only 18.75 percent people can survive the whole year by their land production. Many locals (41.66 percent) can survive with their agricultural production for 3 to 6 months. More than a quarter of the total households do not have food sufficiency even for 3 months. It clarifies that farming alone is not sufficient for their food supply; as a result they are compelled to choose other alternative sources of income.

***Animal husbandry*.** Animal husbandry, basically transhumant herding, was the most familiar and common source of livelihood till four decades back**.** Most households had either cows or buffalos or both, and goat, sheep, yak and *chauri* (*Zomo*) (Bishop 1998). In Melamchi Ghyang, pastoralism is not a communal activity but rather one of the individual family entrepreneurship. Many respondents interestingly shared that they were born in yak sheds and cow sheds and some even in the jungle. But nowadays the pastoral lifestyle has shifted into modern living, as villagers are more likely to go abroad (mainly India) for work. Seasonal migration to various places of India is very common.

Many villagers go to India to work for 6 to 9 months in a year, and animal husbandry has decreased magically. Now only 3 local farmers have yak sheds and 3 have (*Zomo*) *chauri* shed. They generally shift their shed every month. When the temperature increases they shift to higher altitude and reach the highest altitude of about 4000 meters in June/July. They also collect herbs and bring to the village for herbal medication.

Culturally yak and their hybrid offspring are herded primarily by Tibetan-derived groups (Bishop 1998). Hyolmos are also a Tibetan derived group and herd mainly yak and *chauri*. Yak is the male and its female is called *nak* in Tibetan. Yak cannot survive below 3000 meters altitude. For better milk production and easy survival of them, the crossbreed of yak and cow, or bull and *nak*, produces hybrid. Its hybrid male is called *zopkio*, which is used to carry load like the donkey. It cannot produce offspring. The hybrid female is called *zomo* or *chauri*. The purpose of breeding *zomo* is to produce milk, not calves.

Animal herding and farming are combined in Melamchi Ghyang in different ways, depending on the local situation. The local people have animal sheds in which the herds are moved through a series of pastures over the year in a pattern determined by the climatic and nutritional needs of the animal. Now there are limited cases of transhumant

herding. Some farmers practice animal rearing in their home in a small scale. A small number of chickens are found in almost all houses, 30 HHs keep cows, 4 HHs keep oxen, 6 HHs keep buffalos, and goats are kept by only 2 HHs (see Annex Table 2).

Foreign employment. Foreign employment is now very common in Hyolmo region. It is regarded as one of the major economic sources. They mainly go to India and some of them have gone to the US, Israel, Korea, UK, Hong Kong, Canada, Finland, Dubai and Kuwait. At least a family member from 75 out of the 96 households in Melamchi Ghyang has gone either of these countries to work. Bishop (1998) states that; the circular migration to India is another source of income. Most of them (45.83 percent) are in India. They work in different places of India such as Ladakh, Himanchal, Arunanchal, Assam, Delhi, etc. They work there from February/March to October/November. Indian returnees shared that a single worker can earn some 50 to 60 thousand rupees and a couple can earn 1 lakh to 1.5 lakh rupees in the period of 8-9 months. The returnees from India informed that they get involved in different physical works like in hotel, construction labor, contractor, etc. Nowadays, the economy of Hyolmos is strengthened by this practice. On the other hand, Indian and Western medical/treatment culture has also entered the remote Helambu region.

Some sexagenarian informants shared that a group of Hyolmos went to Burma to work some 40-50 years ago. It was probably the beginning of going to work in another country. Now, old Hyolmo informants call Burma even for India. Bishop (1998) states,

> People referred to external migration as going to Burma. Some people had actually gone to Burma, but in fact, their destinations included Gangtok, Sikkim, Assam, Bhutan and a number of places in the eastern Indian states of Arunanchal Pradesh, including the Buddhist pilgrimage sites. Jobs of Melamchi men and women included road building, porter, breaking up and carrying rocks and mud, and building construction. Women ran tea shop or hotels where workers lived. By 1986, more of circular migrants were working in western India like Kashmir, and Himanchal Pradesh. (p. 71)

Desarlais (2003) states that, with the multifaceted, ever shifting "ethnoscapes" of Nepal in 1990s, many families and youths moved to Kathmandu in search of employment, better education for their children and to spend more comfortable life.

Then, many Hyolmo youths left Kathmandu and went to developed cities of different countries such as New York City to look for better paying jobs. This process shifted their culture into modern.

Sometimes men with their women were found going to work in Indian cities. While men predominate in external migration, women are well represented. They go there for earning, pilgrimage, or performing funeral rites of those who died in India, and those living abroad come back to village to meet their family members, relatives, and renew cultural ties with their village. Some people have come back due to the conflict between Buddhists and Muslims. Bishop (1998) states, ten people returned from Ladakh due to such conflict in 1989.

Job and business. A very few people are job holders in Melamchi Ghyang. Only 6 persons are involved in schools and health post as job holders, which is 6.25 percent of the total population. These job holders have better economic status than those who do not have jobs.

Only eight households have their guest houses. The local lodge owners informed that tourists came earlier than when the government formally opened Helambu as tourist area and Langtang trekking route. Tourists were accommodated either in personal houses or used tent and stayed in open area those days. The first lodge opened in this area is Sun Lodge, which is now closed. There are two seasons for foreign tourists, and each season covers almost three months (i) September, October and November and (ii) March, April and May. The respondents shared that more tourists come in the second season. Some foreign tourists seldom come in off season.

A very few people of low land (*Rongwa*) used to come to Melamchi Ghyang to exchange potato and radish with grains. Some of them used to go to buy cattle or to work as porters to supply food stuffs. Now the scenario has changed along with the development of road. Many native people also go for trekking, pilgrim, tour and business. The local people do not have any other remarkable business except for some small shop inside their home. There is a hotel run by non-local, non-Hyolmo Kamal Basnet, who supplies the necessary goods and food items.

The people of Melamchi Ghyang have their home in Kathmandu as the next economic resource in the form of rent: 48 households have houses in the Boudha area in

Kathmandu and 26 households have land in Kathmandu. This implies that majority of the local Hyolmos are economically sound.

Melamchi Ghyang area is situated near Langtang National Park and is rich in herbal resources, but the herbal and forest resources are not used for selling. If anyone uses the products without the permission of community forest users group, the person is charged with a fine of up to Rs. 5,000—Pasang Lama, the chairperson of the group, said. The local mothers groups also protect the forest, claimed Putali Hyolmo, a member of mothers group. Other jobs of Melamchi people such as weaving, spinning, paper making, and wood carving have almost disappeared. Two villagers make artistic 'Tungna', an example of wood carving. It is a musical instrument, made of the wood of rhododendron, used by Hyolmo.The traditional medical practices are gradually changing due to contact of local people with low land people and tourism in the area.

Social aspect. Hyolmos were recognized as Lamas and Sherpas in the past but they got their distinct identity as an ethnic group through the *rajpatra* published in 2058/10/ 25 B.S. Then, Hyolmos are socially recognized by the states, who are residing in Helambu region for centuries. Hyolmos have different clans: *Ghale, Lama, Yowa, Jhyawa* and *Shyangwa*. Hyolmos have strong unity and good harmony. There is no discrimination towards widow/widowers: their remarriage is easily accepted.

***Respected persons in the Hyolmo community*.** Respect offered to someone signifies people's perception towards him/her. The elderly person in Hyolmo community is respected. Male elderly people are respectfully called *Mheme* and the title given to elderly respected female is *Ibe*. The Lamas, *Jhankris*, teachers, social leaders etc. are respected persons in the community. The degree of respect is given in table 8.

Table 8: ***Respected Persons in the Community***

Respected Person	No. of respondents	Percentage[2]
Lama	90	93.75
Educated person	81	84.37
Political leader	2	2.08
Wealthy person	5	5.20
Bhombo Full respect	48	50
A little respect	16	16.66

[2] Percentage exceeds 100 due to multiple responses.

Need-based respect	3	3.12

Source: Fieldwork 2014

Lamas are the most respected and prestigious persons in the community, so other people also try to adopt Lamas' practice. The process was termed Lamaization by Clark (1980 a), like 'Sanskritization' by Srinivas in 1952. Clark (1980 c) states, "There can be Lamaization by wealthy group who see their future in terms of some 'pan Tibetan' tradition" (p. 5). Lamas perform rituals. They perform different activities for prevention of health problems. As the table 8 shows, 93.75 percent respondents claimed that Lamas are the respected persons. Educated persons such as schools teachers are the second category: 84.37 percent respondents said that educated persons are respected, but a few respondents shared that teachers are respected by those people whose children are studying in school. Interestingly, a respondent shared that respect towards educated people decreases if the educated person has no job. *Dhami/Jhankris* (*Bhombo* in local language) are the third respected category: 50 percent respondents shared that *bhombos* also are the respected persons, 16 respondents shared that they have little respect towards them, whereas 3 respondents said that they are respected when they are in need.

Interestingly, Hyolmos have very little respects towards political persons and wealthy persons. They were found having less interest in politics. The society gives equal value for both rich and poor. Those people who had more parental property and high income were respected in the past, but now they are not in the category of respected persons, as almost all Hyolmos in Melamchi Ghyang are prosperous economically.

***Family structure*.** Hyolmos of Melamchi Ghyang have two types of family structure on the basis of the number of family members: 71.87 percent households are found in [3]nuclear family and 28.12 percent in joint family, but no household was found under extended family category (see Annex Table 3). The reasons for more nuclear families are due to education, urban impact, and awareness on family planning. Desjarlais (2003) notes that Yolmo *wa* (people) live for the most part in the households composed of nuclear family, although sometimes parents end up living with their adult sons and

[3] Nuclear family consists of a couple (and their unmarried children), and a joint family is the family in which more than one couple or more than two generations live together.

daughters. When sons marry, they usually set up their own households, sometimes on land adjacent to their parents' home.

After marriage, a daughter goes to her husband and sons start to live separately as nuclear family in this community. The youngest son with his wife lives with old parents after his marriage. It is their tradition.

Concept of family planning. In the household census in the field, majority of the household heads (78.12 percent) responded that they know about family planning; and only 21.87 percent answered that they do not have idea about it (see Annex Table 5). Those household heads who had this idea knew about it from school education, adult literacy classes, foreign job or from TV and radio. Those who said that they do not have idea about it were basically the old informants.

***Women's status and decision making*.** There is low degree of gender discrimination among Hyolmos in comparison to their surrounding communities. In Melamchi Ghyang, 57.29 percent decisions are taken by father alone, 23.96 percent by mother; and 22.91 percent by both of them jointly after discussion. Out of the 96 respondents in the household census, 59 had male household heads and 37 had female household heads. This shows that females also have remarkable role in the community (see Annex Table 6).

Women in Melamchi Ghyang also have gone abroad to work. This shows that women also contribute to household economy through remittance. When the daughter gets married, there is a culture of helping by son-in-law in father-in-law's house. He has to involve in agricultural work like ploughing field, digging, firewood collection, etc. This culture further supports the higher status of women. But the educated son-in-laws help through economic support instead of physical participation. The next interesting right given to women is that a newly married woman can break the relation after some days or months if she dislikes her husband. If she gets married to the next man, she becomes free by paying *jari*. There are instances of continuing married life even if they do not have children for long period. There is no polygamy, but it was prevalent in the past. There is no discrimination against widows, and their remarriage is accepted. These instances support that women have better social status in Hyolmo community.

Relation with other communities. Exchange of women, goods, and labor within the relatively small region link people together, bringing them into frequent contact. Without telephone, regular mail service or telegraph, people remain connected through face-to-face exchanges and social network (Bishop 1998). Now, Melamchi Ghyang is not an isolated valley, and those families living out of village have a touch with non-Hyolmo people. Acceleration of transportation and communication has further enhanced their relation with other communities.

Hyolmos had very limited relation with other communities particularly with Brahmin/Chhetri till four decades back. A few low land people (*Rongwa*) used to have contact with them. They came to Melamchi Ghyang as porters to supply food stuff, to buy cattle or to exchange potato and radish with grains. They visited the place frequently after the establishment of school in Melamchi Ghyang in 2045 B.S. The visit increased with the political changes and with road connection. Now Hyolmos have better connection and harmony with non-Hyolmos. When Helambu was established as a tourist centre and trekking route, the number of native as well as foreign tourists increased. It is a pilgrim for Buddhists and pilgrim route for Hindus to Gosainkunda. That also contributed for the interaction of Hyolmos with other communities.

Kinship. Hyolmos are tied up by both consanguineal and affinal kinship. They have their own term in their language to call the relatives, such as *Mheme-Ibe* for grandfather and grandmother, *Appa-Aama* for father and mother, *Aada-Nwo* for elder and younger brother, *Aaji-Nwomu* for elder and younger sister, *Bhu-Bhomu* for son and daughter, *khyowa-Bhimi* for husband and wife, *Aani-Asyang* for father-in-law and mother-in-law, *Asyang-Jheche* for brother-in-law and sister-in-law, *Chho-Chhama* for nephew and niece, etc.. Some terms represent two or more relations such as *Aani* (mother-in-law and sister-in-law) and *Aasyang* (father in law, brother in law [elder or younger] and maternal uncle) etc. Fictive kinship (like *mit*) is also rarely practiced. *Miteri* relation is established by worshiping god/goddess and exchanging gifts.

Nekor. The tradition to visit sick members in Hyolmo community and wishing to get well soon is called *Nekor* in the Hyolmo language. The community members go to meet the sick person or a woman after childbirth. They go to visit the patient with a bottle of alcohol, three eggs, and some fruits. These items are given to the patient or to the host

as a token of respect. This culture is followed even if the patient is fully well after recovery. In the past, people used to visit to the terminally ill, but now they go to meet even in minor illness. This culture has contributed to establishing the 'we feeling' and communal unity among them.

Cultural aspect. Hyolmo culture is guided by Buddhism: 99.78 percent of the populations in Helambu are Buddhist (CBS 2001). All the local people residing in Melamchi Ghyang are Buddhists, and the rituals are conducted according to Buddhism. Lama is the important person in every ritual. Also, feast is arranged in every ritual. Though the culture is a broad term, I have tried to define this by linking it with rituals in this topic.

***Birth (Bhansang)*.** The birth of the child of a married couple is taken as a special event. Both male and female child are equally accepted. The mother and new baby are cared by family members. The mother is fed with mutton and chicken soup brought from other village, soup of *Jwano*, ghee and other energy giving food. Lama performs *puja* for purification for five days from childbirth. This ritual is called 'Bhansang' in the Hyolmo language. According to Hyolmo culture, the cycle of twelve years is represented by twelve animals such rat, ox, bird, snake, tiger, etc. The year changes with Lhosar festival. In the year 2014, the Snake Year ended and Horse Year began. It is believed that the nature of the child develops according to the animal year on which the children are born. After the completion of 'Bhansang' the relatives observe the face of new child and offer *khada* and presents.

Naming Ceremony (Tapchi). Generally, naming ceremony is completed by Lama. The name is given on the basis of the birth year and birthday for both sexes. Therefore repetition of the name for many people in the village is very common. Sometimes Lama gives the auspicious name abruptly as he thinks appropriate for the person. Lama gives the name to the new child joining his own name, as it is believed that the evil power runs away if the name is kept after the name of Lama. Some household heads keep the modern name of their child by his/her interest, or sometimes by joining the name of their famous and powerful ancestors. The following names are kept for their children irrespective of sex on the basis of birthday.

Table 9: ***Naming of Hyolmos based on the Day of Birth***

Day	Name
Sunday	Nima
Monday	Dawa
Tuesday	Mingmar
Wednesday	Lhakpa
Thursday	Phurba
Friday	Pasang
Saturday	Pemba

Source: Key Informant Interview, 2014

It is difficult to identify a child's sex only on the basis of name as children of both the sexes get the same name according to the birth day. The middle name is also kept in Hyolmo community to separate them from others. The middle name has particular and valuable meaning. Some common middle names and their meanings are given below in Table 10:

Table 10: ***Name of Hyolmos and their Meaning***

Diki	Healthy and joyful
Dolma	Star
Dorji	Thunder bolt
Lhamu	Goddess
Namgyal/Gyaljen	Victorious one
Norvu	Precious gem
Sonam	Fortunate one
Tashi	Auspicious one
Tenjing	Upholder of religion
Tshering	Long life
Tshokyi	Spiritual
Wangyal	Powerful one
Yesshe	Wise one
Zhangmu/Zangbu	Great one

Source: Key Informant Interview, 2014

Their middle names are also common for both sexes. Thus the sex is not identified on the basis of name alone. Some villagers who lived in India have the influence of Indian cinema. Nowadays they have started to keep names following the name of film stars. The name of a local female was found Shree Devi and a local male was Akshya Kumar. There is no feeding ceremony in Hyolmo community, like in caste groups. The new child is fed when s/he can eat and feels needy, and this may be any day, month or time.

Marriage (Bhama). Marriage is taken as an important event in Hyolmo community. Generally love marriage and arrange marriages are in practice: 67.70 percent HH heads prioritize love marriage because they claim that both the partners understand each other. The HH heads also accept the choice of spouse. Similarly, 25% HH heads preferred arranged marriage and 7.29% HH heads were interested in love-cum-arranged marriage (see Annex Table 7). This picture clarifies that the practice of love marriage is increasing, but marriage by elopement and polygamy are not preferred by any of the HH head, neither are these practices found. Bishop (1998) states that; marriage by elopement was practiced by Hyolmos in the past.

As there is increasing ratio of love marriage, inter-marriage is also increasing: 82.29 percent HH heads accepted that inter-marriage is a common practice in their community, whereas 9.37 percent answered that there is a rare practice of inter-marriage and 8.33 percent HH heads did not accept that inter-marriage is in their community (see Annex Table 8). This practice began in recent days when the Hyolmo male and female started working abroad or went to Kathmandu city, or due to education, transportation and communication but Bishop (1998) states that clan inter-marriage was the traditional practice among them.

Table 11: ***Responses of HH Heads on Appropriate Age for Marriage***

Appropriate age for marriage	Response of HH heads	Percentage
16-20 years	1	1.04
20-25 years	39	40.62
26 above	48	50
As per interest	5	5.2
Do not know	3	3.12

Source: Fieldwork, 2014

The HH heads were also asked about the appropriate age of marriage and their reasons. The majority (50 percent) of HH heads responded that above 26 years is the appropriate age, 40.26 percent claimed that the appropriate age is between 21 to 25, and 5.2 percent answered that marriage should be done at the time of their interest, and a single HH head said that the appropriate age is 16 to 20 years. Table 11 show that there is no practice of child marriage; but the practice of late marriage is widespread. People informed that there was child marriage practice in the past. Bishop, (1998: 104) reported, "There are several cases historically of very young marriages in Melamchi, both boys and girls, at 12 years of age". Now they share that the age after 21 years is better because they can understand each other. They also can earn and read, and they are conscious of their health as they become physically mature. They also informed that family stability increases if they get married after 21 years.

The traditional ritual of marriage is called 'Bhama' in the Hyolmo language. In the arranged marriage, the bridegroom side proposes for bride with *'Syalgar'* (a full bottle of alcohol offered as present along with money), also called *'Toljung'* in the local language, and *khada* (colorful piece of holy cloth). If '*Syalgar*' is accepted by the brides' parents/guardian, it symbolizes that the proposal is accepted. It is called *'Dejang'*. The process of offering '*Syalgar*' money and *khada* from bridegroom's side to bride's side second time is called *'Lhanjang'*. This process further confirms the marriage. Then Lama observes the birth timing of both boy and girl (*Makpa samba*) and determines the date of wedding; then the invitation is offered to relatives. This process is called *'Bhunjyen'*. The third function related to marriage in *'Toljyang'*, which is the two-way agreement to tie up on the relation between wife and husband. *Syalgar*, money and *khada* are to be offered again from groom's side. Both bride and groom are offered blessings by the seniors. Feast with alcohol is common in every step of marriage.

Death rituals. Hyolmos believe that death rituals should be conducted properly so as not to turn the departed soul (*sindi*) into *pisach* (evil power) and to get rid of its torture to the people. The dead body is burnt according to Buddhist tradition within the 3 days of death. Lamas worship every 7 days for the peace of the departed soul. This purification process is called *Melam*. After some days of death, Lamas write the name of the dead person in a paper, recite mantra and burn the paper. This ritual is called *Nebar*. A big

puja (*Ghewa*) is performed on the 49th day of the death and the last puja (*Hyangya*) is performed within a year.

Worshiping by the Hyolmos. Hyolmos worship various gods/goddess related to Buddhism, wishing that evil power cannot torture the community people. Most pujas are performed at local Gumba for collective welfare and a limited puja at every home. There is major role of Lama in each puja. Some worshipping is done by the head of the family or some by *Bhombo*s. Their duration, repetition and procedure differ based on the nature of worship. The major pujas performed in Melamchi Ghyang are given in Table 12.

Table 12: *Pujas performed by Hyolmos*

Puja performed	Time of worship	Place of worship
Kul puja	Every year	Every home
Chhejyu Puja (Bachhyam)	Every year	Gumba
Sang (purifying process by firing incense)	After the birth of child and Before the performance of each *puja*	In each home by Lama
Mhani Bum	Yearly	Gumba
Kangyur (Recitation of 108 text of Buddhist philosophy	Before five days of Buddha Jayanti	Gumba
Hyum (recitation of 16 Buddhist text by Lama)	Before five days of Buddha Jayanti	Gumba
Tengyur (Lamas recite 1000 Buddhist text)	During Buddha Jayanti	Gumba
Rahamne (*Puja* performed by Lama to fill spirit for god)	After the construction of Gumba	Gumba
Nyungne (fasting by any interested people)	Three days strict fasting which ends on Purnima of Dashain	Gumba

Source: Key Informant Interview, 2014

Health and hygiene aspect. All the houses in Melamchi Ghyang are facilitated by drinking water, but it is not distributed to every house, neither the purified water is distributed. Taps are kept in public places at the centre of some houses. Water is brought through pipeline from the rivulet and stored in a tank with a capacity of 10,000 liters.

The house yards are clean. People are aware of their cleanliness. As Bishop (1998) states, bathing and washing practices were taught by European trekkers in the 1980s. The things in the house are properly managed in such a way that any new person

gets surprise watching the arrangement. There is toilet in each house. A single house was found having no toilet: the family members shared with the close neighbors' toilet. Proper disposal of faeces is very important for people's health. Unsafe disposal creates various health problems.

For defecation purposes, a decade ago, all houses had similar temporary pits where dry leaves were disposed. It would be useful instead of using water in winter due to cold. Also, it was used as manure in the field. Recently, due to urban impact, people have started to build concrete toilets in which water is used. Now 71.87 percent people have temporary pit, 21.87 percent have '*pakki*' toilet and 6.25 percent people have started to make '*pakki'* toilet (see Annex Table 9). Melamchi Drinking Water Project provides Rs. 3,000 for the construction of a concrete toilet. This assistance has somehow attracted the locals to make concrete toilet. Bio-gas production would be the best use of defecation in the toilet, but bio-gas is not possible in this locality due to altitude.

People are aware of immunization, after the establishment of health post by the help of Community Action Nepal (CAN); the locals go to health post even in a minor health problem. They do not depend only on *Dhami/Jhankris*; rather, they go to health post or hospital of Melamchi Bazaar or Kathmandu. Some people go to hospital of Kathmandu by helicopter charter in urgent and serious cases. Such events happen two to three times a year on the basis of need even in recent years, because road is not reliable during the summer season. There is no bridge to pass the vehicle across the Melamchi River between Nakote and Melamchi Ghyang.

Living in the cold climate, generally people are healthy. Their morning begins with salty tea. They use the flour of roasted grain (*saatu*), bread, and *chyura* as breakfast after puja in the morning. Nowadays biscuits, noodles and other readymade items are in use. Some people make vegetable *Mo Mo* and *Thuppa* sometimes. *Dhindo* is their staple food. They use rice, bread, potato, *daal*, egg, *syosa* (curry made with whey), *hrildo* (mixture of *syosa* and potato) etc. as common food. Being the cold, soups of various kinds are used.

Their staple food is potato, rice, porridge (*jhamba*), *syakpa* (item mixture of potato and wheat flour), and bread. Rice is rarely used because they do not have rice field. Now rice is bought from the market. They use tea and *saatu* (flour of roasted grain),

which is called '*Jyamdor*' in their language. *Saatu* is also eaten as breakfast by making small balls called '*polda*'. It is also made of millet, oat, *karu* and maize.

These varieties of food are available in the local area and they protect from cold. Many people use alcoholic liquor and salty tea in a large amount daily. It has affected negatively in people's health. Many patients with blood pressure and diabetic mellitus (sugar) were found during the study period.

Religious aspect. Hyolmos of Helambu region are Buddhists. Some people of lower Helambu (mainly so-called low caste) are found attracted towards Christianity. But Buddhism is the main religion of Hyolmos (Dahal 2069 BS).

In case of Melamchi Ghyang, all locals are Hyolmos and are Buddhists. All local HH heads claimed that their main god is Buddha. Few of the Hyolmos claim that they follow Mahayana, but many of them are not familiar with any of the sects under Buddhism. They follow the philosophy of many historical religious *gurus* such as Guru Padhmasambhava, Guru Rimpoche, Sange Chyomdende etc. as the incarnation of Buddha. Desjarlais (2003) states that most Yolmo people are devout practitioners of the 'Nyingma' school of Mahayan Buddhism.

Traditionally Melamchi Ghyang is a Buddhist religious center. There is Tupu cave, also called Chandra Surya cave ("Moon Sun cave," as there are figures of sun and moon on the ceiling of the cave), at the top of the village adjoining the jungle, where Guru Rimpoche meditated in the 8th century. The village contains several important religious sites. The local gumba is the second oldest gumba of Hyolmo region.

Table 13: *HH Heads' Responses on their Main Deities*

Main Deities	No. of HH head	Percentage
Buddha	96	100
Kul Devata (Kangsu)	96	100
Guru Rimpoche	6	62.5
GuruPadmasambhava	44	45.83
Sange Chyomdende	36	37.5
Manjushree	8	8.83
Dalai Lama	6	6. 25

Source: Fieldwork, 2014

Hyolmos may follow more than one god/goddess. HH heads claim that all the above-mentioned gods are the form of Lord Buddha except for *Kul Devata* (ancestral

deity). All respondents have full respect towards Buddha and *Kul Devata*. Also, 62.5 percent HH head responded that they follow Guru Rimpoche. 45.83 percent follow Guru Padmasambhava and 37.5 percent follow Guru Sange Chyomdende. These three are the pioneer religious *gurus* who meditated in different times in Helambu and expanded Buddhism. Hyolmos regard Guru Padmasambhava, Guru Rimpoche and Sange Chyomdende as different names of the same person. Rimpoche in Tibetan means "great guru." They all are taken as the great gurus under Buddhism. Only a few locals view that they are not different. Very few people told the name of Manjushree and Dalai Lama as their main god. Thus, different locals regard different deities as the main god. Whoever they follow, they follow Buddhism. Their priest is Lama. Lamas are skillful persons who perform rituals for purification. They are the most respected persons in Hyolmo community.

Sonam Lhosar. Sherpas celebrate '*Gyalbu Lhosar'* but Hyolmos celebrate *Sonam Lhosar*. In this sense Hyolmos are different from Sherpas. Hyolmos share that *Gyalbu Lhosar* is the *Lhosar* of Tibetan king and Lhosar for ordinary people is Sonam Lhosar, which is celebrated by them both inside and outside the country. *Sonam Lhosar* is the main festival of Hyolmos. Lhosar is the term formed by the combination of two terms: 'Lho' means year and 'Sar' means new, so Lhosar means New Year. Hyolmos celebrated 2850th New Year in 2014. The year is based on Tibetan lunar calendar. The single circle of this calendar is completed in 12 years. The time repeats on the Tibetan 12-year cylindrical cycle. Each year is conventionally associated with a familiar animal whose essential nature summarizes certain metaphysical, psychological, and cognitive aspects of being. Each year is represented by an animal such as rat, ox, tiger, rabbit, horse, sheep, snake, monkey, bird, dog, pig, etc. A special festival called '*Rating'* comes after five circles, i.e., at 60 years, which is celebrated greatly.

Sonam Lhosar is celebrated for two weeks in late January and early February, begins from the first day after dark moon in the month of Magh, and continues till the next full moon day. Hyolmos share their joys and sorrows, wish for better days and progress, clean their house and surroundings, and eat delicious dishes of bread, potato and beans with alcohol. They erect the religious flag (*Daring*) in their house yard. They pray and worship in Gumba and their own home with lamp and incense. This festival is

the symbol of family and social unity. People come back who are out of village or abroad.

They celebrate other festivals like *Narah*. It is celebrated in August. The main attraction of this festival is making of artistic bread of wheat with salt as '*prasad*', which is distributed to their neighbors and relatives. The other remarkable festival is Buddha Jayanti. As Buddha is the main god, they celebrate Buddha Jayanti greatly in Gumba.

***Thal (Guthi*).** There is a social organization under the local Gumba that organizes locals for any social tradition, puja, religious function and rituals. It is like *Guthi* system of Newars, in which each and every member have their own role and responsibilities. Each Gumba has a separate *Thal*. There is a single *Thal* in Melamchi Ghyang. Male household heads who own land are members of the *guthi*, which maintains the village gumba. *Gova* is the head of this organization who guides every function. *Gova* is chosen from among the *Thal* list. The members choose their responsibility on a lottery basis. The same responsibility continues for one year. The responsibilities such as distributing tea or alcohol, cooking, cleaning etc. are written on a paper. It helps to maintain the social harmony and to complete any ritual successfully. *Thal* collects tax and pays to gumba proportional to the size of their land holding.

Females cannot be its members because females do not inherit land. Widows appear in the *Thal* list but they hold the membership for their sons. When a son inherits his father's land or buys land, he can pay the fee and become a member. The members of family who do not have land are auxiliary members of *Thal*. Interestingly, no person other than Hyolmo has land in Melamchi Ghyang.

The members of Thal (*Thal wa*) get help only from other members of the community. So, its membership is almost compulsory. They get economic and social support from *Thal wa.* Non-locals do not get its membership now, but some Tibetans who came late in the locality had got the membership in the past. A new local member has to pay certain amount earlier to get its membership. The amount gets doubled if any member leaves membership and comes to join again. Therefore, even if a person is out of the country, he requests other reliable person (may be a brother) to fulfill his responsibility of *Thal.*

Summary

This chapter portrayed the socio-cultural, economic and educational picture of the district and Melamchi Ghyang, Helambu VDC. The aim of this chapter is to provide a picture of the study area, which will help to locate different medical practices in the larger context and a better context to answer the research question formulated in this research.

Even a single ethnic group that resides in a specific place has various socio-economic and educational diversities. Different households were found with different statuses which guided the choice of health service providers. The culture of Hyolmos also seems to be one of the dominant factors that determine their health status as well as medical choice.

CHAPTER V:
HEALTH CARE AMONG THE HYOLMOS: MEDICAL PLURALISTIC PARADIGM

This chapter analyzes the perception of Hyolmos on the various kinds of illnesses, sicknesses and diseases and their preventive and curative medical practices. These medical practices are analyzed into the popular, the folk/traditional and the professional categories on the basis of theory applied in this research. This chapter also discusses on the reason to use more than one health-seeking strategy by the people of the study area.

Minocha (1980) considers medical pluralism to mean the co-existence of multiple medical systems, such as folk, traditional and scientific medicine within one overall system. Hsu (2008) states that medical pluralism "implies that in any one community, patients may resort to different therapies even when these have mutually incompatible explanations for the disorder" (p. 316). Medical Pluralism exists in Hyolmo community. The practices existing in their community are explored on the basis of Explanatory Model of Kleinman (1978).

Climatic situation of Helambu is a boon for Hyolmos. The maximum temperature is 30 degree Celsius in summer, whereas the minimum temperature falls less than zero degree in winter. Snow falls at least once a year. I also observed the event of snowfall during the field work. Helambu gets 3 to 4 times snowfall in some years. The cold climate has supported people to be free from many major diseases. Some informants shared that they have not taken even a tablet of paracetamol so far for their health problem. But it does not mean that they remain always healthy. They use alternative medicine – mainly herbal practice – and *Dhami/Jhankri* for their illness when they feel sick. Many informants shared that they have strong belief in their traditional practices rather than modern medicine. People have their own reasons of practicing the traditional medicine: they trust a practitioner more if he or she is somebody from their own community who is culturally accepted. A traditional medical practitioner is very much familiar to the family's medical history and the traditional medicine is cheaper and affordable even for the people with less income. The next reason to choose them is that the practitioner is more likely to be a family member as well as a counselor to all the members.

Combination of various kinds of medicine is practiced even for a single health problem in the locality. A case study below shows the same.

Case Study 1: Plural Self-Medication Practices

Putali Lama is now 46 years old. She is an active member of mothers' group and one of the social leaders. She was born in jungle area when her parents were transhumant herders. She says that she was brought home keeping in a wooden milking vessel after her birth. Like her, many villagers above 30 years old now were born in jungle living in Melamchi Ghyang. Talking about her childhood period she further says, "There was no school in this village in my time and did not get chance to learn. But now I am literate through adult literacy classes."

She wakes up at around 7 am like other villagers, makes salty tea in firewood. She offered me a cup of tea and said '*shey shey*,' meaning 'drink drink'. She also uses LP gas occasionally. We started to talk about different medical practices she follows on various illness episodes, she explained, "There was not any hospital based medicine; neither the health post nor doctors in the village till before a decade. People cured the illnesses either by *Bhombos* (*Jhankris*) or by themselves using home made medicine. *Bhombos* were popular to avoid evil spirit (*lagu panchhaune*). I believe that they they have such power to make *sindi* away. If not, how can they tell the causes of illnesses, past events and future of patient? They find cause and suggest the best possible remedies."

In the past, local herbs were used as medicine such as *kutki*. Hot water with turmeric is used for common cold and *bojho* for cough. Being liquor drinker community (*Pieune jaat*) we drink local alcohol also for medicine. We also massage body with hot alcohol to make relief from pain. A few people, who know the use of other substances, also use them to be cured from many problems. Now the health post medicine (allopathy) is in practice when it was established. The villagers use *bhombos* healing, homemade medicine and medicine from health post at the same time when they feel ill. But the healing process that they choose differs in each person.

She claims, She applies plural medical system when she feels ill even today. '*Upachar rog anusar hunchha. Sabai rog ko upachar eutai bidhi bata huna sakdaina*'.

Each treatment is according to the illness. The treatment of all kinds of illness is not possible by a single system. Some illness can be treated in one way and the next treatment is more appropriate in the next illness. Such as *Lagu* (illness by spiritual cause) is treated by *bhombos* and physical wound is treated by health post in better way.

The case study shows that many kinds of alternative medication practices are used combinely and the destination of people differs based on the individuals' priority and beliefs.

Causes of Illness

Some people suffer from general health problems due to cold, mainly common cold, cough, uremia for old people, headache, pneumonia for child, fever, cold diarrhea, body pain and wound. In the present day, some people are suffering from gastritis, high blood pressure, tuberculosis and diabetic mellitus. The local Mina Lama called these diseases *'Saharia rog'* (urban diseases). They began in the rural area and when urban contact increased. Other informants also had the same voice. More people believe that they have high blood pressure due to excessive use of salty tea and TB caused by smoking. It is their culture to drink tea many times in a single sitting. They claim that these problems came in village recently and increased due to urban impact after the area was connected with transportation and communication and the people went abroad to work.

People in every community have their own solution for health problems. The differences in procedure, tools, times, sources, service providers, etc., have made the concept of pluralistic paradigm on medical practices useful to study among Hyolmos. The practice of medical pluralism is universal with the incorporation of alternative or complementary therapy. In non-Western societies, traditional medicine is practiced with indigenous and religious healing rituals.

There are different arguments about the causes of illness among Hyolmos. The informants who are aware in their health – mainly teachers, social workers, local leaders, and the people with formal education – shared that diseases are caused when people do not maintain personal hygiene, are in mental tension, or make overuse of alcohol and

follow the habit of smoking. They said that disease is caused by the maladjustment of people in the environment, polluted air and water, and imbalance in temperature. The disease is also caused by low immunity power and carelessness. Many people who are deprived from formal education claimed that they fell sick due to the evil spirit, and disease is caused when gods become angry.

As the locals believe that there are various causes of illness, they also have different solutions of each problem. They follow preventive and curative medical practices like in other communities. There exist mainly the following plural medical practices explained in terms of the Explanatory Model developed by Kleinman (1978 1980), who developed a widely used model that recognizes three overlapping sectors in health care traditions.

By medical practice, I understand a complex configuration of symbols and practices, situated in certain socio-cultural, economic and historical context, which has as its main purpose the management of illness. Kleinman (1978, p. 86) asserts that illness is experienced and reacted into three sectors: the folk/traditional, the professional and the popular. I have compared and incorporated Hyolmos' medical and healing practices within these three sectors since it is part of pluralistic health care system.

The Popular Medical Practices

In the popular sector in Kleinman's (1980) model, a non-specialized person, usually in the household, uses a general body of knowledge to cure illness. It consists of treatment practices conducted by sick persons themselves, their families, relatives, social network and communities. It includes a wide variety of therapies such as special diets, herbs, exercise, rest, and baths or over-the-counter drugs. This sector includes the following practices in Hyolmo community.

Food habits. The staple food of Hyolmos is porridge (*jhamba*), *syakpa* (item mixture of potato and wheat flour), bread and potatoes. Rice is rarely used because they do not have paddy field. Now rice is bought and used. Every morning begins with salty butter tea at around 7 a.m. They use tea and *saatu* (flour of roasted grain), which is called *Jyamdor* in their language. *Saatu* is also eaten as breakfast by kneading small ball called '*polda*'. It is also made of millet, oat, *karu* and maize. The breakfast time is about 8 a.m. Generally they do not go to work in the morning.

Their lunch time is at noon. It is not late for them as they use heavy breakfast. Even the school students and teachers come back home to take lunch. The hostel students also take lunch at the same time. They do not have the concept of balanced diet. A few of them have cow shed in jungle and some of them have kept cows and buffalo in their home yard (see Annex Table 2). About 48 percent people have chicken. Milk, ghee, curd and eggs are common in their food, which supplies necessary protein for body. Meat is very rare as they have not slaughtered animals for two decades in the village, as they are Buddhist. But according to the villagers, they eat dead animals and some people bring meat occasionally from other villages.

They commonly drink *raksi*, a local alcohol made of wheat. All food items are eaten adding more than one time. They believe that food items become impure if they are not added. Such traditional culture to add food to make it pure is called *Temka* in their language.

They produce vegetables such as cauliflower, cabbage, and other green vegetables. Potato is produced in large quantities. They also use beans frequently as curry. Helambu was famous for apples till two decades back, but Melamchi Ghyang could not produce better because of the lack of the idea about pesticide, insecticide and technical manpower. Bishop (1998) states,

> The apple orchard in Melamchi has never been successful, probably because there was no consistent attention to it by Chiniya Lama family members. The trees can produce good apple but many are misshapen, insect ridden, small and flavorless; Monkeys, deer and livestock are a nuisance and can spoil the trees and the crops. The orchard has fallen into disarray in recent years (p. 59).

Even then, they have planted apple trees. Many families in the village have planted a few apple and peach trees in their house yard for family consumption.

The food items they use fulfill their diet automatically. Nowadays, they sell their local production and have started to buy readymade food items like Horlicks, beaten rice, noodles, biscuits, etc. Many educated people claim that diseases are caused by these food items. An educated local, Sonam Hyolmo, explains, "The flour of *karu*, the main food item of Hyolmos, is very much energetic, but neither the locals know about its

importance nor does the doctor know the local reality. Doctors suggest using Horlicks. Therefore, Hyolmos also began to use Horlicks."

In this way the local fresh food, vegetables and milk and their timely use have helped to make Hyolmos healthy traditionally. Usual food items automatically maintain their diet. Changes in their food practice have weakened their health status. They have a culture of drinking salty tea, adding again and again. The frequency of drink is also high. Many informants claim that local people have suffered from BP due to this practice.

Sanitation. Low population density makes the absence of any sophisticated sanitation system, other than household latrine areas (Bishop 1998). All the house yards are clean inside and outside. Toilet system began in the 1980s along with tourism development and foreign employment. Every house in Melamchi Ghyang has toilet facilities, except for two houses. Those households having no toilet share their neighbors' toilet. There are 78.12 percent households having temporary pits where dried leaves (*patkar*) are disposed and 21.78 percent households have concrete (*pakki*) toilets; 6.25 percent households have the *pakki* toilets under construction (see Annex Table 10). It shows that all the people of the area use toilet. The reasons to make toilet in every house yard are education and awareness, economic wellbeing and the impact of tourism in local area. Helambu was declared Open Defecation Free (ODF) on 10th Ashar 2071 B.S. It is the 50th VDC of the district to declare ODF.

They have the culture to use the deposit of *kachhi* toilet as manure. It began due to not using water in cold region and there was water problem in the past. Now, there is piped water supply in every quarter of houses. Open water pipe is seen in many places of the village. Source of water is at a distance of about two kilometers. Water is neither filtered nor purified; however, the cold water from the mountain is drinkable because it is not contaminated. However, there is problem of drinking water due to the lack of proper management. Lanam Lama, a local political activist, informed, "There are enough water sources but it is not utilized. There is a 12,000 liter cemented tank and a 10,000 liter plastic tank under use but the problem is to bring water from source."

Self-medication. Self-medication is one of the oldest practices of treatment that is still prevalent in every society. It is the use of medicine without consulting the medical persons. The sick person uses household products for treatment which is in one's personal

access, and practices of various forms of treatment are connected to his or her social power in relation to other household members. Household productions of health examine how household members cooperate and compete for resources in order to restore, maintain and promote health.

Self-medication is more common among women, young people, those living alone, individuals of low socio-economic status, sufferers of chronic ailments and psychiatric conditions. Poverty, high medicine cost and non-availability of doctors in rural areas make health care inaccessible, and consequently, pharmaceutical outlets serve as the first contact point of health. Self-medication is widely prevalent in Hyolmo community of rural Helambu. The reasons, as they state, are that there is no tension on fees for medications, burden of diagnosis and examinations, transportation costs**,** loss of time for the patients themselves and their assistants, and remoteness. Besides, they feel comfortable to use it as it is their tradition. When self-medication is not effective, patients go to the hospital for treatment, when it is often too late.

This process defined as self-care represents the range of behavior undertaken by individuals to promote or restore their health. Kleinman (1978) states that in both Western and non-Western societies, individuals self-treat 70-90 percent of health problems at home. These decisions to self-treat are made by laypersons who face real symptoms and who seek to improve their health without medical supervision. A layperson may choose to delay professional assistance until there is failure of home remedies or worsening of symptoms. Among the Hyolmos, during my fieldwork in 2014, I found that about 53.12 percent people used self-medication in Melamchi Ghyang (see Table 15). Hyolmos use homemade herbal remedies and tonics or sometimes allopathic medicine too if they are available. They use herbs, manually remove obstructions, and apply heat compression, dietary restrictions and prescriptions as the major self-medication practices. Their medical traditions and practices are based on religion and beliefs regarding cosmos. Generally such medical problems are first treated at the home with some remedies suggested by relatives and neighbors. When several attempts of self-medication fail, then they go to specialist – either traditional or modern – for their treatment. Massage in the body part where there is problem is also practiced by them for recovery.

Self medication among Hylomos comes in their first attempt – mainly using the local herbs. This statement is also supported by the following narration of Dev Raj Dahal, a high school teacher residing in Hyolmo region for two decades. He informs:

> Hyolmos medicate their own self in each health problem at first. They medicate at household level in many illnesses such as by keeping the leg in salty hot water if it is swelling, sugarcane for jaundice, hot water with turmeric for common cold, *Bojho* for cough, etc. Sometimes they drink local alcohol by heating for common cold. Alcohol is used to massage in body pain. It is cheap and reliable.

The practice of self medication begins from home with the help of family members. It is a common practice of healing as there is lack of medical experts in local area. This is supported by a local informant, Prakash Hyolmo, a social leader who lives in Kathmandu and goes to village occasionally, who I met in the field:

> When I am at village, if I am sick, I use what I have at home. If this does not work, I ask around family, friends, see what things (medications, remedies) they have. Then I will go to the health post if it is still bad. I sometimes buy medicine and use for diarrhea, cold and cough. I also use hot water or hot alcohol in common cold. It is widely practiced by all Hylomos in our area. I also take some normal medicine from Kathmandu when I go to village and use when necessary.

Alcohol is found as a common drink in Helambu. It is believed that it treats the problem caused by cold and makes the body strong. It is a holy drink for them which is used even by Lamas and other religious persons in their rituals. This theme is supported by Kami Lama, a local social worker. He believes:

> Alcohol makes our body strong. We use only local made alcohol. Hot alcohol is used in the problem of common cold and cough. It is also used for massage for body pain. It was also drunk by Guru Rimpoche in the past. It is reliable too. But it will not be effective for those who have the habit of drinking regularly.

Self-medication is much prevalent in Hyolmo region. It is faster, easier and sometimes better as well. It comes at low/no cost. There is no need to pay doctor's fee, transportation cost or medicinal cost. Hyolmos have protected cognitive knowledge and practice of healing. This is an example of its success (see case study box below).

Case Study 2: An Example of Self-Medication

Mani Prasad Adhikari, the head teacher of Pema Chhyoling Lower Secondary School, Helambu-6, Nakote, lower to Melamchi Ghyang, is from Sindhuli and is living in Hyolmo area for 17 years. He has taught many medical ideas to Hyolmos and made them aware on the one hand and learnt many healing ideas from Hyolmo people on the other hand. Here is his experience of self-medication.

Five years ago his wife (also a teacher) suffered from stomach pain. She was taken to a hospital in Kathmandu and was diagnosed that there was a gallstone of 19 mm. Surgery was compulsory to get relief, but she came back without treatment. He was trying to arrange leisure time for at least a couple of weeks; he also had to remain on queue in hospital and had to arrange a huge amount of money for surgery.

When he came to village, an experienced Hyolmo villager suggested using *gahat* (lentils used like pulse). Then he started to use. He explains with fresh mood, "I brought about 8 kg lentils and started to use for wife. It is soaked in water in the evening and that water is drunk in the next morning. Water changes to red color. The seeds are used as pulse and eaten. When it was continued for a week regularly, the stomach pain decreased and later fully stopped. When the lentil finished, I discontinued it. After two years, the pain began again. We went to the same hospital and diagnosed a 15 mm gall stone. Then I went to Dhulikhel Hospital because the hospital where I went first was expensive. Dhulikhel Hospital decided the operation date after 15 days and we came back home".

He further clarifies about the importance of *lentils*, "I bought 5 kg of lentils again and did the same practice which we had done two years before. The pain stopped in a few days. We went to hospital thinking that problem may repeat, but there was no problem at that time. The hospital could not find any stone in video x-ray, but operation was done on the basis of the report of 15 days before according to the advice of doctors. Finally a few dust portions of stone were found."

He further shows the significance of self-medication and says, "Had we continued using lentils regularly there would not be the need to do operation, no need to invest money and no need to bear such tension. I suggest using lentils occasionally to everyone to be away from stone problem."

Self medication is significant if right medicine is chosen in right time. It can cure even big problem related to health without surgery, in a very low cost and without tension.

Exercise and meditation. People do not have regular exercise for their health fitness. The villagers argue that there is no need for any special exercise as they live in a hilly village. Regular walk and movement maintain their exercise.
Meditation is common in Helambu region but not for physical health; it is for mental peace. Some foreigners also come for meditation for religious purposes as meditation is common in Buddhism. When I was in field, a US and two Korean citizens were meditating in the local Chandra Surya cave above the village. There could be observed the symbol of sun and moon on the stone ceiling of the cave.

There are four caves around Melamchi Ghyang. The villagers believe that Guru Padmasmbhava (believed as incarnation of Buddha) had meditated in the 8th century in the cave. "Generally Lamas involve in meditation because it is believed that their knowledge will be incomplete if they do not meditate. Other common people also meditate to get knowledge and to know soul and god," said Lopsang Lama, a local social activist. Meditation is common practice under Buddhism.

The villagers shared that some foreigners meditate in the jungle above making a shed. They take food once a day or some of them do not take food for some days and complete their meditation. It can be in any time and any season for the purification of soul.

Ethno-medical practice. Ethnomedicine or folk medicine comprises knowledge systems that developed over generations in various societies before the era of modern medicine. World Health Organization (2008) defines traditional medicine as the health practices, approaches, knowledge and beliefs incorporating plant, animal and mineral-based medicines, spiritual therapies, manual techniques and exercises, applied singularly or in combination to treat, diagnose and prevent illnesses or maintain well-being. Practices known as traditional medicines include Ayurveda, Siddha Medicine, Unani, ancient Iranian medicine, Islamic medicine, traditional Chinese medicine, traditional

Vietnamese medicine, traditional Korean medicine, acupuncture, traditional African medicine and many other forms of healing practices.

Folk ideas and practices associated with treatment of illness available within local cultures is ethnomedicine. They commonly involve empirically based natural remedies from plants and healing rituals with supernatural elements. Ethnomedical analysis focuses on cultural systems of healing and the cognitive parameters of illness.

Ethnomedical practices on healing are major emphasis in medical anthropology which uses *emic* approach to describe healing system. It includes different indigenous medicines practiced by people. Actually it is the study of ethnography of health and healing behavior of different societies. It includes herbal and other folk practices described in the respective sections below.

Herbal practice. The World Health Organization (WHO) has estimated that more than 80% of the world's population in developing countries depends primarily on herbal medicine for basic healthcare needs (Vines 2004). Medicinal plants are the primary source of medicine for 70-80% of the mountain population; and they solely rely on traditional medicine and health care, since access to other health care systems is non-existent (ICIMOD 1994). The herbal practice to cure illness is widely used in rural areas. It is the traditional practice that community people use medical plant products available nearby. The knowledge of herbal medicine stems from spirituality, customs, livelihood strategies and the resources available nearby. Medicinal herbs are main ingredients of traditional herbal medicine, and the traditional herbal medicine is considered as the main lifeline (Kunwar *et al*. 2009). Herbal medicine is a good example of indigenous knowledge, which has affected the lives of people all over the world (World Bank 1998).

Hyolmos follow different herbal practices traditionally for the recovery of health as they live in the storehouse of various herbs. All the informants answered unanimously that they use *kutki*, a local herb, for many illnesses such as fever, gastritis, diarrhea, common cold and cough. It is soaked in hot water for three to four hours and then drunk. It is very bitter in taste but very much effective and useful for health recovery. Locals have strong belief in it. It is available above the altitude of 4,000 meters. *Kutki* is brought by the cow, sheep and yak herders who go up in high altitude in summer while shifting

animal shed and give the locals as present. There are many other important herbs that can be found in local jungle as the village is joined with Langtang National Park.

The herbs found in the local jungle are *Jatamasi, Nirmasi, Panch aunle, Yarsa gumba, Ban lasun, Ban satuwa, Ban karela, Chiraito, Bojho,* rhododendron and so on. Among the herbs, *panch aule* is used for and *chiraito* for cough and fever. But many of the villagers do not recognize them, nor do they know about its use. There is also the problem of skilled manpower to collect herbs. On the other hand, people are not allowed to enter the jungle area to search for such herbs.

There is a saying by many local informants about herbs. One of the informants interestingly informed that she knows the name of medicine but she should not tell the name of medicinal herbs because she has a belief that medicinal herb does not work effectively if she utters its name.

Kamal Basnet, a businessman living in Melamchi Ghyang for two decades, was asked about the herbal practices done by Hyolmos to get the outsiders view in this regard. He explains,

> *Kutki* is the most familiar herb used for fever, cold and cough. *Chiraito* is used for cough and fever. *Taling* (scented herb) is used with water for gastritis and *Panch aule* is for diarrhea. A famous herb *Yarsagumba* is also found above 4000 meters height. Hyolmos, till two decades ago depended either on *Jhankris* or in herbal medicine. Almost all villages had cow/yak shed; they used to go up shifting their shed and collected the herbs. The people in the past could recognize the herbs. Now only a few old Hyolmos recognize herbal plants but they cannot climb up the hill being old. Today's people neither can recognize nor collect the herbs.

Many informants clearly expressed their ignorance on medicinal herbs. They do not recognize the herbs and for what problem they can be used. If they know, they do not have the idea to use. Chairperson of community forest shared,

> Here are no professional herbalists. People are not allowed to enter jungle in search of herbs. There are very few people who know herbs. A few herbs can be used by locals for their medication but it is not for sale. The national park has completely banned the collection of herbs for more than a decade. The people

from other areas used to come to collect herbs in the past. We the locals did not know its value. Now we all are alert.

Because of the modern facilities and ignorance of the use of folk medicine, herbal medical practices are decreasing. Now, this practice is replaced gradually by readymade allopathic medicine found in local health post.

Folk/Traditional Medical Practices

The Report of the International Conference on Primary Health care, Alma-Ata, USSR, 6-12 September 1978, as cited in Warren, Bova, Tregoning, & Kliewer (1982), contains an important reference to traditional medical practitioners**.**

> Traditional practitioners and birth attendants are found in most societies. They are often part of the local community, culture and tradition, and continue to have high social standing in many places, exerting considerable influence on local health practices. With the support of the formal health systems, these indigenous practitioners can become important allies in organizing efforts to improve the health of the community. Some communities may select them as community health workers. It is therefore well worth while exploring the possibilities of engaging them in primary health care and training them accordingly (p. 1874).

This statement accepts that traditional practitioners exist in most societies and have responsibilities of health towards local people. The traditional or folk medical practice of Hyolmos based on Kleinman's model is analyzed here.

Kleinman (1980) identifies as the folk sectors in which healing is performed by non-professional, non-bureaucratic, specialists who are trained informally or happened to have an experience where they felt it was their calling. This sector is considered an intermediate level between the popular sector and the professional health care sector. I have incorporated the following practices in Melamchi Ghyang under the folk sector.

Kul Puja (Kangsu). *Kul puja* is performed after Sonam Lhosar in different ways according to their clan. There are five clans within Hyolmos, *Ghale, Syangba, Jhhyawa, Yoba* and *Lama (Lhalungba*). *Kul puja* is called '*kangsu*' by *Syangba*. They invite Lama for '*kangsu*' but *Jhhyowa* invite *Jhankris* in this *puja* and they call *Lhakyunge* for the *puja*. *'Lha'* means "god" and *'Kyunge'* means "process to please." Basically it is done in two ways. The small *puja* called *'Fichyang'* is performed every year in every home. If the

bad days come for the family members, it is done immediately on any day. The big *puja* is more difficult to perform as it needs collecting materials and is costly. The materials like drum, *torma* (statue of flour), rice, piece of colorful clothes, alcohols, etc., are needed for big *puja*. It is performed by Lama in Gumba every three years in general. In the Ghale clan, the household head has to sacrifice goat on this occasion. Nowadays, animal sacrifice is stopped and milk is offered instead. It takes one full day to perform the big *puja*.

The main aim of this *kul puja* is to avoid misfortunes in the family, to wish prosperity of the members, and to expect peace, healthy life, and good days. Lamas perform *Kangsu* for the betterment of new generation. Hyolmos believe that it brings good days, better health and progress. They have the belief that *kul puja* should be performed every year as far as possible, as they relate *kul puja* with their personal and family security. Migrated Hyolmos also perform it by inviting Lama in their residence.

Lama. Sickness is a religious affair and religion is an essential factor in the healing process (Lambo 1998/99, p. 156). Religion and healing practices are interlinked. Lamas are religious persons as well as healers. They are the Buddhist priests who have studied religious texts and perform religious functions. They recite *Tripitak,* a holy book of Buddhism, and worship in *gumbas*. They perform *puja* to make the god happy. They pray for the success of new task. They never sacrifice animals.

Lamas are the respected persons in the community whose advice is not disobeyed. Every villager has strong belief over Lamas' performance. Being Buddhist followers, every home has a decorated corner set aside for their gods. High places are often the areas of worship because they believe that gods live there. Their flags with prayers written on them are hung with the hope that god will protect them.

There are two well known local Lamas who perform every religious activity and ritual. Senior Lamas come from Boudha and Swoyambhu in Kathmandu occasionally. Nowadays, many youths including girls have attraction towards Lama *Bidhya* (Buddhist Education) as it is a respected job. Lama *Bidya* is also taught up to grade five in the local school. Interestingly, almost all informants shared that their performances have not been changed from the known time. The villagers believe that the god will be angry if any worship process gets changed. But one of the informants criticized about the changes,

claiming that Lamas have started deciding collectively about religious activities which were not done in this way in the past. He further adds that the holy book used by Lama has also changed. There was the religious book with loose sheets; when the pages were lost, they bought a new book. The new book is in a bounded form and some texts inside are changed. It clarifies that there are some changes in worshiping. But local Lama Tenjing does not accept the changes on their performance. He strongly argues,

> The previous texts were on hand script but the same texts are in printed form now. There is no change in Lama Education. We cannot change the text made by ancient Lama experts, Guru Rimpoche. We have no right to change. We should not lose the originality. Lama text is not like politics to change.

None of the rituals from birth to death will be completed in the absence of Lama. They are the important persons for every ritual. Naming ceremony is performed by Lama in Hyolmo community. The name is given to the child on the basis of the birth day. Sometimes Lama gives the auspicious name abruptly as he thinks appropriate for the person. Sometimes the name of the child is joined with Lama's name as the locals believe that evil power cannot govern his body and the child will be healthy for the whole life.

Hyolmos believe that 25, 37, 49, 61, and 73 years of life are bad years for them. Lamas pray to minimize the effect of bad time and to bring good time. Lamas believe that the cause of illness is spiritual and not the biological and healing is accomplished through prayers, blessing and offerings.

Lamas perform *puja,* light the lamp, offer water and recite *Tripitak* to avoid bad time of the community and to make good omen in the beginning of any new task. There are *pujas* performed many times in a year in Gumba. Such occasions are twice in main Dashain, and once in Lhosar, Buddha Jayanti, Chaitra Dashain and in Shrawan. A separate *puja* is performed in the case of death. They work for collective welfare for peace and better agro-production. Many informants have a strong belief that all the wishes are fulfilled, child studies well, and grief and pain go away when Lama worships. So, their role is more preventive than curative in the health issues. But sometimes they heal patients using mantras and light the lamp for the recovery of patients' health.

Despite their involvement basically in preventive healing, Lamas are considered more as religious persons than the traditional healers. They perform *puja* and put on lamp

for the collective welfare of community wishing for the good days. Lamas are the most respected persons in Buddhist society. Hyolmos, being Buddhists, also have strong faith over Lamaism. Performance of a Lama is portrayed by himself in the case study below.

Case Study 3: Lama: The Ideal Character of Society

Tenjng Lama of Melamchi Ghyang, a respected Lama found very genuine by his character and conduct, shares that there are two types of Lamas: *Thare* Lama means Lama by surname and *Padhe* Lama means Lama by their education. He is under *Thare* Lama but has studied Buddhism. He says, "Hyolmos have faith over *Thare* Lama but it is wrong, *Padh*e Lamas are educated. They study four subjects under Lama Education. *Nyingma* is the oldest education system begun by Guru Rimpoche. Now its main follower Guru Tarun Rimpoche is in Simla, India. There are many followers of this branch. Many Hyolmos are under this branch. The next branch of education is *Kagyue*, whose present guru is Guru Karmapa Rimpoche and he lives in Dharamsala, India. The third branch of knowledge is *Gheluk*, followed by Guru Dalai Lama. And the fourth is *Segya*, whose followers do not believe in incarnation. The eldest son of existing guru becomes its inheritant. The main guru of this sect is in Deharadun, India".

There are about 200 textbooks under the most familiar *Nyingma* education. Among them *Jhyngdel*, the text of about 1600 pages, is read the most. It is written in Lama Script. There are different texts read in different rituals.

Lamas are preventive healers. They watch grains, tell the fortune and predict the condition of the patient. Some Lamas have magical power whose predictions come true. They have meditated for years and got perfection (*siddhi*). They are powerful as they could have achieved the god power. Such Lamas are very rare and not found in Hyolmo region.

He further explained,"I am happy to be Lama because it is a good profession. It is done for the well wish of all. Religious functions are performed in Gumba such as Lhosar and *Kangso* (*kul puja*) for collective welfare. Lama education is taken by many Hyolmos but they have not implemented. It is taught even in schools up to primary level. It is difficult to become actual Lama because hard and long term meditation is needed. I have meditated for 6-7 months."

It is a social work and not a lucrative job. Anything offered by villagers should be accepted, he says. There is no culture of further demands of anything in return.
He explains that both male and female can take Lama Education. But female has no right to perform *puja* as Lama in Gumba. She becomes nun. Except for this provision, male and female are equally treated in society.

Talking about the changes in their practices he argues, "There are no changes in Lama practice and no one has right to change it. The knowledge created by Guru Rimpoche in the 8th century should not be changed. If changed, what is the importance of Lama? Some changes in dress code and some materials is not the change in knowledge. If we tried to change, senior Lamas who often come from various Buddhist centers may know. We have no interest to change because this knowledge is not the ordinary. It came to exist as the product of strong meditation."

As Lama is associated with Gumba, he explained the history of Melamchi Ghyang Gumba in an interesting way, "Chiri Ghyang just below Tarkeghyang Gumba is the oldest historic Gumba of Hyolmo region. Sinen Wangel Dorje, the 4th incarnation of the main Lama of that Gumba Najyang Sejya Jangbu made Melamchi Ghyang Gumba in 1670-1675 B.S. Sinen Wangel lived here for 17 years and moved towards Rasuwa with his two sons Chhetang Dorje and Ghyalsang Dorje because the villagers did not follow the religion properly and did not become his disciples. Melamchi Ghyang is the second oldest Gumba of Hyolmo Region which was made 396 years ago. It was repaired and maintained in 1991 the last time. The actual name of this Gumba is Gonpa Hopame kye Lharkhang Gumba, and later Chiniya Lama came here with royal power and changed the name of Gumba as Urgen Chhyoling Chiniya Lama Gumba".

As a preventive healer, Lamas can satisfy god/ goddesses through their religious rites. They watch grains and tell the fortune and future of patient. People believe that they have achieved power of god. Therefore they are respected as ideal person.

Dhami/ Jhankris (Bhombo). It is estimated that there were four to eight hundred thousand faith healers in Nepal in 1978/79 (Shrestha & Lediard 1980). Justice (1986) states, there are *jharne* and *fukne* for this treatment system. *Dhami/Jhankris* drive away

the negative spirits which harm the people, using positive spirit. There exist various traditional faith healers in Nepal. Dhami/Jhankris as the traditional healers exist in Helambu since the time immemorial. They are well known accepted intermediaries between man and spirit.

Jhankris are respectfully called *'Bhombo'* in Hyolmo language. Hyolmos believe that there is no difference between *Dhami* and *Jhankris*, but the local people use the term *Jhankri* or *'bhombo'* in their language to refer to both the terms. *Bhombo* is joined as surname after a *Jhankri's* first name. The healers also claim themselves as *Jhankris*. So, I also have used the term *Jhankri* in this research. There are four *Jhankris* in Melamchi Ghyang, and two of them were found in Kharchung, the next village near Melamchi Ghyang, Helambu. They all are males. I asked the villagers that why there are only male *Jhankris* and they answered that illiteracy of females is its main cause. As mantras need to be read, illiterate cannot practice. Even literate females are not involved in it because they were excluded traditionally in this sector.

Among the *Jhankris* in Melamchi Ghyang, two are elders. One of them shared, "I had learnt *mantra* from the teacher (*guru*) of Nuwakot. I left this practice a decade ago due to my age, but the next one still practices. We taught three junior *Jhankris."* On the history of this practice, both the elderly *Jhankris* mentioned that there were few minor *Jhankris* about 50 years ago. When the crisis in people's and animals' health appeared after the death of the then *Jhankris*, they learnt to fulfill the local needs. They refer the patients to these gurus of Ghyangfedi, Nuwakot, in major cases even today. The other four *Jhankris* of the village had learnt this knowledge from the senior local *Jhankris*. They learnt to protect body by using mantras, to watch grains and to observe pulse to find the causes of illness. Nowadays *Jhankris* observe the body of ill person by the witness of god/goddess and utter the problem own self. They also have an interesting technique of measuring sacred rope to find what evil power has attacked against ill person. The two *Jhankris* of Kharchung, a village lower to Melamchi Ghyang, were interviewed and they also had the similar idea to diagnose illness.

Mheme Pasang Bhombo, 83, the eldest among *Jhankris,* shared an event during his learning time.

> When I was just 24, the local old *Jhankri* died and there were no *Jhankris* to treat in the village. I went to Ghyangfedi (Nuwakot) to learn. It was my compulsion as there was no other alternative. My father also forced me to learn. Then I went to the guru (teacher), stayed there for about two months and learnt mantras. I knew the basic mantras to heal such as how to protect the body using mantras, to watch grains, to diagnose problem and to heal. When I came back to village, my body started to shake during the healing time. Then I came to know that I became a perfect *Jhankri,* and then I started to solve any problem created by evil power.

When I asked if he had faced any unwanted results in his life time as a result of healing, he smiled and replied after a bit:

> All patients were treated perfectly. They were satisfied and used to come again when the problem arose… But unfortunately a single case in my life failed. A female patient of this village died as she was brought to the last stage of her life. She was caught by powerful *sindi* (the spirit of dead body). Her time was no longer. I tried my best till the last moment. But I could not save her. Even the god cannot prolong life as it is fixed by birth.

Various traditional faith healers in Nepal such as *Dhami*, *Jhankris* and *Jharphuks* speak, chant, whisper and shout during the performance. *Dhami* and *Jhankris* exist as traditional healers since time immemorial. The *Dhami-Jhankris* exert a lot of influence regarding health matters. Some research works have been done in using them for health. It is believed that they communicate with spirits, recite mantras and cure the patients. Maskarinec (1995) also supports the finding that *Jhankris* are Himalayan shamans, intercessors who rely on extensive training in oral text to diagnose and treat afflictions that trouble their clients. They tell the origin of worldly disorder and the histories of malevolent forces, stories that explain why people suffer, grow old and die. They tell about extraordinary events and exceptional individuals.

Sick persons in Helambu, who eventually visit the allopathic healers, consult the traditional healers as the first hierarchy of resort. There are two types of *Jhankris. Sano Jhankris* involve in *jharfuk* and *thulo Jhankri* worship ancestor god using drum. The patient goes to *thulo Jhankris* in complicated cases. The local Hyolmos go to *Jhankri* in case of heart pain, vomiting and faint. The villagers seek service from the *Jhankris*

whoever they meet at first in case of emergency. Most *Jhankris* prescribe medicinal herbs found in local area of which they possess considerable knowledge.

Jhankris use water, incenses stick, broom, ashes, flour of rice, ghee, oil lamp, cock and other materials in different cases. They beat drum and recite mantras by shaking their body. Generally drum is beaten at night, but *mantras* are used at any time when problems come. The process goes at least for two hours and in some major cases it takes the whole night. In simple illnesses, *Jhankris* heal at any time except for noon and around noon. They believe that their healing will not be effective at noon as the evil power becomes the most active at that time. There was the tradition of animal sacrifice, mainly of cock, by *Jhankris* in the past, but now it is almost stopped. Animals are not slaughtered in the village now. The reason is that the Lama (Buddhist religious guru) suggested not sacrificing animals about a decade back. All villagers are Buddhists and they accepted the suggestion given by Lama. Of late, the villagers who want to eat meat bring it from the next village. If anybody is found involved in animal slaughter, the mothers group charges Rs. 5,000 as a penalty. Karsang Ghale Hyolmo claims that another reason for the decrease in animal sacrifice is the decreasing number of *Jhankris* along with the establishment of health center in 2009. Some informants claimed that animal sacrifice decreased because of the decreasing animal husbandry.

A *Jhankri* claimed, "I can solve every health problem caused by evil power. In most of the cases a single attempt works successfully, but in serious cases more attempts are needed. Many local people search us for their healing because we are easily available in the community". The next reason for preference of *Jhankri* is that there is almost no economic burden with them. They do not take anything in return generally as they are also the members of the same community. Sometimes villagers pay food stuff such as rice and fruits by their own will. Those *Jhankris* who do not have other occupations receive money at a low rate of less than Rs. 500 in an event. The rate of *Jhankri's* fee is not fixed, but they are given reasonable amount on the basis of the duration they give for healing, repetition of visit, socio-economic class of client, severity of patient's ailment, professionalism of *Jhankri* and distance from where they are called. If they are from further distance and have to stay for a long time to heal the patient, they are given reasonable amount. In major cases if *thulo Jhankri* is invited mainly from Nuwakot, they

are given some tribute and money in a greater amount than the amount given to local *Jhankris*. A local informant shared,

> The *Jhankris* were only the single local alternative in the past, and they were satisfied with their healing too. We believe that *Jhankris* can treat the illness which modern hospital cannot diagnose. If the health problem increases gradually at night and the patient starts vomiting, or suffers from heart pain, body pain, headache, or if '*sindi'* causes illness, then we people choose *Jhankris.*

Jhankris' success compels one to think about the existence of some supernatural power which is beyond the knowledge of modern science. The reasons to follow them are that they are not expensive, they are easily available, and the practice is culturally accepted. *Jhankris* go to the patient's home at any time and treat them so that patients need not to be taken away from home and there is no need to be separated from family. It is psychologically important for rural people. So, mainly the local elderly people still have a strong belief in *Dhami/Jhankris*. But the young and educated people prefer to go to health post and hospital. They think that *Jhankris* tell lies and cannot heal the patient, that it is just a superstition that they can support only psychologically.

Jhankris claim that they can heal the patient which the hospitals cannot treat. They can pacify the evil power with their mantra. They have such magical power for healing. Locals also have strong beliefs over their practices. The case study below in the box illustrates their practices as an example.

Case Study 4: Healing Event by a *Jhankri*

Sher Jangbu is a 67 years old, the most senior *Jhankri* of Melamchi Ghyang among the practitioners. He learnt *Jhankri* knowledge from the Guru (teacher) of Ghyangfedi, Nuwakot, at the age of 17. His father and grandfathers were also *Jhankris* and he learnt the basic knowledge of healing from them. Later he stayed about six months in Nuwakot with his teacher (Guru) to learn the major practice of traditional healing. He claims that he has perfect knowledge of all the mantras which are needed in healing process of different illnesses and has the new lives to many of his clients using his healing technique.

He worships, offers and satisfies god to get god power on him because he believes that this process makes his mantras powerful. He claims, "I can solve the problem of dizziness, heart pain, vomiting, headache and fainting caused by ghost, witch, *sindi* (soul of dead body) and any other illness made by evil power. I have cured innumerable patients during my healing practice of the period of half a century. I first transmit god power to my body using mantras and then I start to heal. No evil power can exist towards me. I make them run away immediately."

He heals patients mainly in the morning hours but heals at any time if the patient is serious. He used to sacrifice animals till a decade back, but now he left sacrificing animals and uses egg instead. He diagnoses the problem by observing faces and watching grains. He does not begin his healing if the patient is sure to die as if he knows the future of the patient. He is famous not only in the village; he is invited in the villages nearby, and many patients from the nearby village come to him for treatment. Sometimes he has to go to Bouddha, Kathmandu, to heal when he is invited by the clients. He claims that he has gone to India to heal very often. His clients are the Hyolmos who are scattered from Helambu and settled in different places of the country and abroad. He takes his fees on the basis of the economic level of the patient. He thinks his job is a social service rather than for earning. He should be ready at any time and situation to serve when the case is serious. Even though he has to take something in return for his survival, he is flexible in the villagers' case. He shared that local patients provide minor gifts such as money, clothes, cigarette, wine, etc., when they become happy after their recovery.

I observed an interesting event about the distant healing that a woman, daughter-in-law of a villager, who got ill in India. She was paralyzed in one side of her body and he conducted healing practice from Melamchi Ghyang. He watched the grains and found that she was suffering from local (Hyolmo) *sindi*. He made a statue (*torma*) of rice flour. There were egg, ghee, flower (blue in color), and three branches of bush, lamp, a glass of milk and an artistic four-sided fire pot, ash, incense stick as healing materials. He began to recite mantra in a loud voice in the beginning. He made his voice low after a few minutes. He took little rice (*Akshyata*) and took the name of god/goddess and offered to the statue. The other collected materials were offered and fire was set on lamp. He moved

the burnt incense around the statue. He offered *akshyata* in the *torma* and finally offered them on all directions. He also took a pinch of ash, applied mantra and offered in all directions including the sky and earth. He clarified this process later that first of all he has to offer to all gods, goddesses and evil power to please them, and then they will be ready to leave the sufferer. He was continuously reciting mantra sometimes in low and sometimes in high pitch, sometimes by opening and sometimes by closing his eyes. The mantra was in Hyolmo Language. He began the words, *Ah...hu...ma...hun*… I could not understand the language. Later I asked him to translate and he clarified its meaning in short: "Oh god, leave to torture, pain, and uneasiness of the woman of this home. I have offered you (evil power) egg, milk, *akshyata*, piece of clothes and incense …" He says, "I have many mantras. I use them separately on the basis of cases. Firstly, the positive treatment is done by offering the things by which they can be pleased. Mantras are also applied positively. There are praising terms in mantra for the power which attacks. If positive treatment is not effective, then the next mantra is applied with harsh words to dominate the evil spiritual power. Broom is used to throw away the evils."

The process continued for about two hours. Finally the erected *torma* was made down. I was thinking that the *torma* would be left at the joint of two ways or somewhere else. But interestingly *Jhankri* ate a few of its pieces and gave to the people who were attending there. In the past there was the culture to distribute it to every household.

After a week I asked the concerned villager about the health condition of his daughter-in-law. He replied that she was completely well then. She could get well in the double attempt. I visited the *Jhankri* again and asked about the level of satisfaction of his job. He shared in cheerful mood, "I am happy with my job. The god gave me the power to learn. Anyone who wants cannot learn it. It is not easy task. Sometimes powerful evil spirit attacks even me too. I also can be ill. I should be careful while healing. So it is a challenging job too. Now, I have prestige, name, and some property. I have got chance to travel. Many people demand my job. So, I am happy."

Jhankris claim that they get power of god on them and attack against evil power using their powerful mantras.

Aamchi. *Aamchis* are the traditional healers related to Tibetan medicine. They treat using herbal medicine by studying the Tibetan text. *Aamchi* means "Himalayan doctor" in Tibetan language. Helambu is a habitation of Hyolmos, who were Tibetan migrants, but there is no *Aamchi* practice traditionally. Old informants shared that their ancestors were forced to migrate from Tibet and they were illiterate and backward. When they migrated, none of them had the idea about *Aamchi* practice.

There is no *Aamchi* in Melamchi Ghyang, but locals are familiar with this term and practice. There is a single *Aamchi* in Nakote (a village of Helambu, next to Melamchi Ghyang). Dawa Renjen Hyolmo, 61, is the *Aamchi* who has neither taken formal education nor is it his traditional job, but he has simple idea about *Aamchi* practice. He treats patients who come to him by looking at the Tibetan book. *Aamchis* do not use mantra; they use only herbal medicine. He diagnoses the problem by observing the face and the affected body part. He also asks about the symptoms and the history of illness. Sometimes he himself goes to other villages. This practice is reliable mainly for jaundice.

Prakash Sherpa experiences that he used the medicine given by *Aamchi* of Nakote for a long time when he suffered from jaundice. Then due to his effective treatment, he started to believe in *Aamchi.*

The *Aamchi* himself is confident in his practice. He claims that he has provided the reliable and the cheapest healing service to the villagers. His views are stated in the case study box below:

Case Study 5: *Aamchi:* The Tibetan Herbal Practitioner

The single *Aamchi* of Helambu is Dawa Renjen Hylmo, 61. He began this practice from his childhood. His father and grandfather were not *Aamchis*. He went to Himanchal, India, at the age of 18 and learnt the general knowledge of *Aamchi*. When he came back after a couple of years, he got a Tibetan book related to *Aamchi* healing practice from the Gumba of Tarkeghyang, where his youngest son lived. The book, as I observed, was written in Tibetan language and was published in 1971. When I asked him to translate the title of the book, he translated as "Medicine of all Diseases". The text explains the herbs and their uses with figures.

He did not learn from any teachers. He studied the book deeply and found the medicines of many illnesses such as common cold, fever, jaundice, diabetes, food poison, snake bite etc. He said, "No teacher taught me. I studied the book and followed accordingly. Now I can treat effectively". He claims that he can recognize more than one hundred herbs. The medicinal herbs are found only in high altitude and he has to go up hours to get them. He uses fruits, flowers, barks, roots, leaves of different plants for different diseases. Herbs are to eat, smelled or massaged in particular part of the body where the problem is and some are used as juice. For example, sinusitis is treated by inhaling.

He diagnoses the problem by observing the face and affected body part. He also asks about the symptoms and the history of illness. Recently he has found the medicinal herb for diabetic mellitus. It was taken to Delhi to use and got success. Patients from Kathmandu and the village nearby come to him for treatment. The number of new patients is increasing along with old followers. Now he is busy in his job.

Some herbs are already brought and kept in stock at his home. He showed some herbs to me and explained about their uses. Some herbs are to be collected promptly. His family member, mainly his wife, knows a little about the herbal medicine. He plans to teach this idea to his son in the coming days.

He has not determined the price of medicine. He states, "I think, it is a social service. I do not expect anything from the patient. I am satisfied with the service that I am providing to the villagers, but the consumers offer something like *syalgar* (local alcohol offered as present), *Khada* (holy piece of cloth offered like garland in Buddhism). Some people offer a little amount of money."

I asked him what the little amount is. He hesitated first and after sometime smiled and answered that the amount is Rs. 100 to 500. He claims that some consumers ask for medicine free of cost and he gives. At the time when I was with him, a patient of jaundice came from the next village. He immediately brought herb in about 10 minutes and mixed with another herb and gave to the patient. The patient gave Rs. 200 in return and took the medicine.

He shared his own experience of snakebite. Snakes are found in Helambu in spite

of the cold climate. "About 5 years, once I was working in the house yard. At the same time a snake bit my right palm and it started swelling at once. Then I took poison out by cutting in the wound. Black blood mixed with poison came out and red blood started coming out finally. Then I used the herbal medicine that I knew. I applied the medicine regularly for five to six times and I recovered completely."

He claims that he can treat diabetes, food poison, jaundice and many health problems. Minor problems are solved with a single dose of medicine, but jaundice, snake bite and diabetes need up to 3 or 4 doses to get complete recovery. When I asked whether all patients get recovery or not, he gently answered that all patients do not get recovery but these cases are rare. He refers to go to other health service providers in such situations.

Traditional safeguard customs. Hyolmos have various traditional safeguard practices for being safe from probable evil attacks. *Bhakal* is the traditional practice made by some Hyolmos for their safeguard. It is the promise made by a person to offer a religious gift or dedication to a special god. It is made for Hindu goddess Palchok Bhagawati situated in Palchok VDC near Helambu. Besides this goddess, Bhimsen Dolakha is the next destination for *bhakal* in Hyolmos. Hyolmos offer animal sacrifice to Palchok Bhagawati, though they are Buddhists. Lamas suggest not following such tradition, but some locals are still following secretly. Many informants denied this practice, but I could observe a few cases of it. But it is decreasing now.

Bhakal is not done in Gumba, but wishes for peace are made by lighting lamps in Gumba. *Jhankris* used to do similar practices in the past basically to protect their cattle. They used to touch the ill cattle with a cock, give a word to sacrifice, and some time later used to sacrifice the cock in the name of those evil powers when cow/yak shed came down in winter. This practice was called *Songbu*. Now this practice has been discontinued as the practice of transhumant herding has decreased drastically.

Kakani is a name of place found in many areas of the country. There are two places named Kakani in Helambu area. I was curious to know its meaning. I asked the villagers, and mainly the old locals shared that it is an entrance gate constructed below the village as a safeguard of the village. It consists of pictures of gods/ goddesses, and it is believed that no evil power can enter in the village by crossing the gate.

Mascot (*Jantar/Buti*) is the next safeguard used by Hyolmos for individual security from evil spirits. A sacred thread is given by Lama for adult Hyolmos and a mascot for children by *Dhami/Jhankris*. Hyolmos of different ages were observed to use such mascots in their necks and arms to get protected from evil spirit and to be away from illness. Only the same *Jhankris* who had offered the mascot can remove or change it. This tradition is decreasing now.

Hyolmos occasionally consult the 'fortune teller' (a highly-educated Lama) to know their future. They use protective measures like *puja*, prayer, and offering to get rid of the probable inauspicious time. Such Lamas are not found in local area, so this tradition is not much nowadays prevalent.

Lopsang Sherpa, a social worker, political activist and businessman claimed, "Birth horoscope can be examined by Lama. They can forecast about a person's future as well as can declare about what life a person takes after death. They suggest not taking the patient to hospital if the time of death has come." He further adds a story to give emphasis on the belief in fortune teller:

> There was a renowned Lama who could forecast the fortune. Once he observed his own fortune based on birth time and found that death is very soon. Worrying what to do, he stayed near the window putting an ear prick. When he was in deep thinking, a strong storm came at once and the window hit him strongly in the ear and he died of piercing in the ear.

At the same time Lopsang Sherpa was saying it, a school teacher of local high school remarked that *Jhankris* also predict the future of patient. However, a local Pasang Temba says, "However Lama can find and forecast the future, he tells about good or bad days rather than health and illness, but I cannot believe".

Professional Medical Practices

According to Kleinman (1980), the professional sector includes the trained and educated people in the medical sector who have health related knowledge. They have formal position with privileged social status depending on the society. I have incorporated the various practices associated with health post and hospital services used by Hyolmos within professional sector.

Immunization. Hyolmos are aware about immunization. They take their children to the local health post periodically. The concept of immunization emerged in this area with the practice of going abroad to work. The then people who went to Burma and later India brought this idea about four decades ago. It became more prevalent some two decades ago, when school was established. It is now easier because of the establishment of health post in the nearby area. Before the establishment of health post, they used to go to Kharchung, a health post at the next village and Timbu, the low land village of Helambu- 8. The three health posts have provided health service to the villagers. The villagers commonly claim that they have immunized their children before the establishment of health post in Melamchi Ghyang, and its establishment has made the services more accessible.

Allopathic medical practice. The western medical practice institutionally began in Nepal along with the establishment of Bir Hospital in 1947 B.S. It is relatively a new practice in Nepal; however, allopathic medical facilities are neither reliable nor easily available in rural areas. As Pigg (1995) states, almost fifty percent of the country's doctors, private nursing homes and hospitals are centralized in Kathmandu valley.

The allopathic medical tradition involves both the knowledge about how the general environmental interactions affect the body, and the knowledge about how a specific treatment may counteract particular disease. In case of the Third World and marginalized societies, medical anthropology focuses more on the study of ethno-medicine as they depend on folk and traditional medical practices from the remote past.

Hyolmo region had to depend on shamanism and ethnomedical practices for centuries. Because of the strong effort applied by Nepal government to establish health post in rural areas, Timbu, the lower Helambu, had got a government health post which was the single government health post in Helambu. Bishop (1998) states that, by the mid-1980s, people were more likely to seek medical help in Kathmandu owing to the increased frequency in travel there, greater access to cash, and increased fluency in the Nepali language. However, for the sick villager locally, there was not much change.

The first British Mt. Everest climber from the south, Dough Scott, is working in health sector for the people of high hill and mountain area with his organization Community Action Nepal (CAN) since 1997. The same organization is contributing in

health sector of Hyolmo people since 2000 and established health posts in Melamchi Ghyang and Kharchung. This organization started health service by 2005 from an empty house of a local *Mheme* called Dorje in Melamchi Ghyang. After three years, an ordinary building was constructed as a health post just to the west of Gumba. Each household contributed Rs. 1000 and CAN supported to construct the building. Health service continued there for three years. In 2011, another well-facilitated building in the northern side of village was constructed and the health post was shifted there. Now the health post has the basic facilities of equipments and a nurse.

As Rinki Sherpa, staff nurse of the health post informs, there are minor equipments like thermometer, weighing machine, otoscope, stethoscope, blood pressure meter, and dental equipment. Some doctors visit occasionally and stay for a few weeks. The flow of patients increases during their stay. The doctors are the CAN volunteers. She further shares about the diseases and illness of the locals:

> About four to seven patients of common cold, cough, blood pressure, diarrhea, headache, wound, cut, menstruation problem, delivery, etc., come daily. The number of patients depends on season, and severe cold in winter is the time when patients come in large numbers. I have to refer to other health posts below or Melamchi Hospital or Kathmandu in serious cases. Bone fractures were referred last year. Hostel children who have home in the lower land ask for referrals more.

This service is popular among the people of Melamchi Ghyang. Mainly the school teachers refer people to go to the health post for any sort of health problem. School children also suggest their guardians to go to health post. Now villagers feel lucky to get the basic facilities of healthcare. Earlier they had to go far away for the same facilities. The school's head teacher Purna Gautam shared:

> When I came here in 2041 BS there was the strong tradition of *Dhami/Jhankris* and herbal medicine. I had no belief over *Dhami/Jhankri* and disliked that practice. I used to bring minor medicine like paracetamol when I went to Kathmandu. Daily 5 to 7 people used to come to me to take medicine. Now the Health Post is providing better service.

Establishment of the health post has changed the medical practice of the villagers. It was expensive to get health facilities and the people felt insecure in the past. Kami Lama, a local social worker, asserted:

> There was no health post in the past. Many villagers either had to lose their lives or to go to Kathmandu spending days and a large amount of money for treatment. Some rich people used to go to Kathmandu by spending more than 75 thousand rupees in helicopter charters. Those events used to repeat three to four times in a year. Now due to establishment of health post and road transport, people feel secure. Now, we wish a hospital to be established here.

The villagers also claim that traditional healing system, mainly *Bhombo* (*Dhami/Jhankri*), is also decreasing after establishment of the health post.

Interestingly, an old male informant shared that the health post service is doubtful because it is new and the nurse always gives the same medicine for any case. Pointing to the nurse, the next old informant said, "How can I believe the nurse who is smaller than my granddaughter in age?" As he claimed, age is a factor of gaining knowledge and maturity. He further added, "We had solved the health problem ourselves since the time of our ancestors".

The young generations with formal education prefer allopathic medicine more, whereas old people who cannot read and write still prefer *Dhami/Jhankris*. Some old informants and *Jhankris* spoke against health post indirectly. They criticized the activities and medicine of health post and suggested people not to use allopathic medicine because they claim that god will be angry if they use.

In the recent days the followers of *Dhami/Jhankris* are decreasing and allopathic followers are increasing because new generations are familiar with modern education and they prioritize allopathic medicine. Now, *Hyolmo Sarokar Samittee* has started ambulance service, but there is still the problem with roadways mainly in summer season.

The health post is providing service at a very low cost to the local people. After becoming a member at Rs 100 per person, anyone gets the service and medicine for whole year. The nurse informed me that Nepal government provides 47 kinds of medicine whereas CAN distributes 177 kinds. Medicine is brought in every three months. If needed earlier, it can be provided by CAN with prior information.

Education and Awareness

Health literacy and self-efficacy are important for health behavior changes (Mirowsky & Ross 2008). Health literacy and awareness through education are the important preventive measures for illness which is not incorporated under the three sectors by Kleinman. Educated people can find right and wrong practices. Majority (78.12 percent) of Hyolmo people have the concept of family planning (see Annex Table 5). Both male and female respondents answered my questions about family planning without any hesitation.

The local school has contributed to educate the local Hyolmos for three decades. About 62 percent of local people above 6 years are literate (see Table 5). Adult literacy class is running continuously for four years, where adult females in particular learn from the class. They seemed active and happy when I met them. One of the female learners, Putali Sherpa, explained her feeling:

> I am a member of mothers group. This group cleans the environment of surrounding and public place (Gumba), settles minor conflicts in village, and protects the jungle. We all participate in most of these events. We are aware as the result of the adult literacy class. I could not get chance to study in school. There was no school in our time. Adult literacy class has built my confidence. We collect Rs. 10 from each member of this group and help the local poor during their illness.

The mothers group of the village also has aimed to provide economic support to the villagers having less income during their illness. This action became possible by their education and awareness. When I was about to ask the next question, a middle-age woman added:

> I felt guilty when I could not read the letter sent by husband from India. I would be worried about his condition. Establishment of school and continuity of adult literacy class have thrown the light in village life. Now I am happy. I am aware about my health. I go to health post in any illness.

The household census showed that about 39 percent respondents were female. They kindly co-operated me to provide data. They seemed to be frank on sharing any issues of my queries. Many of them are familiar with modern allopathic medicine.

Besides the above-mentioned preventive medical practices, their housing style is one of the important practices as they mostly live in two-story home built with stone, concrete block and wood. Each room of the floor and walls of houses are covered with wooden plank. They do not make cemented house as it is too cold. There is a fire place at the centre of house. It protects them from severe cold. They use long and thick clothes to protect their body. They often drink alcohol. These practices also help them to protect their body from cold.

Reason to Use More Than One Health-Seeking Strategies

It is often said that when health is lost everything is lost. This saying clarifies the importance of health in human life. When people become ill, they want immediate recovery. When one health strategy is applied and no change appears, the patient seeks the next treatment. Thus, more than one health-seeking strategy are applied.

Each society has more than one medical system, and they may well overlap each other. But it may be argued that the totality of such systems constitutes the medical system of that society. In Melamchi Ghyang, people use different strategies and practices for the recovery of health. The reasons to choose more than one service providers are pointed in Table 14.

Table 14: ***Reasons to Choose the Multiple Health Service Providers***

Reasons	No. of Household Heads	[4]Percentage
Easily available	59	61.45
Cheaper	49	51.04
To get well faster	48	50
Belief on all	41	42.70
No belief in single provider	3	3.12

Source Fieldwork 2014

Table 14 shows that the highest number of respondents (61.45%) use more than one service provider because of their availability; 51.04 percent respondents choose only the option if the service is cheaper; 50 percent respondents want to get well faster using multiple practices; 42.70 percent people believe in all sorts of health service providers; whereas only 3.12 percent people have no trust on a single provider.

[4] The percentage exceeds 100 due to multiple responses.

The symptoms that people experience also force to choose more than one healer. Sometimes people experience symptoms of more than one illness. If the sickness begins gradually they go to health post, but if the sickness attacks immediately they take the patient to *Dhami/Jhankris*. People who chose *Dhami/Jhankris* asserted that they were easier than the modern health institutions and they can easily communicate or can express their problem with *Jhankris*. The reason is that *Jhankris* are from their own community. However, Kanchha Lama, a local, says, "Sick people go everywhere for final hope".

The informants are more likely to agree this statement. Some people shared that they medicate by themselves first and then go to *Bhombos* and the health post, but some people informed that they use *Bhombos* and the medicine of hospital at the same time.

Summary

In this chapter, various plural practices followed by the Hyolmos are analyzed. Hyolmos adopt different medical practices, which can be categorized into three broad types on the basis of Kleinman's (1980) typology. The popular sector consists of health care conducted by ill persons themselves, their families, relatives, social network and communities. It includes a wide variety of therapies, such as special diets, herbs, exercise, rest, baths or the counter drugs. Among the popular practices food pattern, cleanliness and sanitation, meditation, self-medication and herbal practices are practiced widely. Hyolmos have developed their distinct ethno-medical practices in any illnesses.

The next medical sector is folk/traditional practice in which healings are performed by trained and experienced healers. Among them, *Kul puja* (*Kangso*) is performed by Lama to avoid bad days and to wish for peace, prosperity and healthy life. *Bombosh* are widely preferred by elderly people in Melamchi Ghyang. An *Aamchi* of Hyolmo region is providing health service in Tibetan herbal system. Besides, they have traditional customs that are believed to save them, such as *bhakal, kakani* and mascot. They also consult the Lamas, who are expert in their fields, to know their future and to avoid probable difficulties. They control cosmic forces through the spiritual prayers.

The third sector is the professional sector. It involves the highly specialized training and knowledge-base, particularly educated providers and biomedicine. Within this practice, health post and hospital services are included. Young generations with formal education prefer health post service, which is established in the village and

providing service in recent years. People immunize their children and take the health service from the local health post.

Education is an important preventive measure of health. In the study area, new generations have got chance of formal education due to the local high school, and elderly people go to adult literacy classes. The reason of plural medical practices found in Hyolmo region is the belief in many service providers who are easily available, and to get well faster.

CHAPTER VI:
PERCEPTIONS ON THE EFFICACY OF MEDICAL BELIEF AND PRACTICE

Health seeking behavior is guided by beliefs, knowledge and attitude about the efficacy of healthcare services. The existence, continuity and effectiveness of medical beliefs and practices depend mostly on the perception of locals. This chapter analyzes the perception of people toward different healers and their healing process. The perception of healers to each other is also analyzed here to explore the reasons of medical choices and priority of the people.

Peoples' perception on the efficacy of a practice is what perpetuate the relevance of the practice itself and that of its practitioner. In this research, I explored how patients view different healers and their respective medical systems. Through in-depth interviews and observation, I was able to gain a sense of what situations and ailments warrant different healers and why people choose certain systems. This study, through ethnography, takes a subjective look at the questions of healthcare options among the local Hyolmos using both practitioners' and patients' perspectives.

The term "efficacy" is broad and complicated to understand. Young (1976. p. 7) conceptualized efficacy in terms of goals, and defined it as "the ability to purposively affect the real world in some observable way, to bring about the kinds of results that the actors anticipate will be brought about." This definition includes the hopes of betterment. More specifically, Young (1983) has defined "medical efficacy" as "the perceived capacity of a given practice to affect sickness in some desirable way" (p. 1208), which he defines broadly as either curing disease or healing illness. Young (1979) argues that efficacy should be determined according to at least three kinds of standards. "Empirical" proofs are anchored in the "material world" and confirmed by events that are explainable; "scientific" proofs are those confirmed through the application of scientific methods; and "symbolic" proofs, the most ambiguously defined of the three, pertain to the "ordering" of "events and objects" that give meaning to, and allow people to manage, sickness episodes. In their totality, what these standards tell us is that efficacy can be viewed from many different perspectives.

Waldram (2000) argues, "Every medical system is a cultural system and is engaged in both healing and curing" (p. 605). Curing and healing efficacy can be distinguished. Within the biomedical clinical encounter, the patient's assessment of the continued existence or elimination of symptoms is important information used by the physician in determining whether a cure has been achieved. Similarly, healing is, in part, related to the assessments made by the physician regarding the patient's condition, based on, for example, elimination of external or objective signs of physiological disorder. Indeed, critical examination reveals that the boundaries between curing and healing are really quite unclear (Nichter 1992). I have used both curing and healing efficacy in this research.

People evaluate the efficacy of healers and choose them in their health problem. Their choice for treatment is also determined by the effectiveness of the healing system. All sorts of treatment are not possible by all healers. Haddix (2002) states, the certain types of illness are more suited to treat by *Dhami* than western doctor in particular illness. Physical symptoms (stomach pain, rashes, and cough) can be treated by doctors whereas invisible symptoms (headache, fainting, dizziness, and seizers) are better to be treated by a *Dhami* or a Lama from the monastery. This is mainly because such illnesses are thought to be caused by evil spirit and can be treated only by a spirit healer.

All health service providers cannot heal all sorts of illness. Some health service providers are more effective in some cases than in others. It is due to the perception of people about how they have perceived such practices. As health and illness are both physical and psychological aspects, perception plays vital role in the choice of healers. In this chapter, the perception of people on different practices, diseases, sickness and illness, and healers' perceptions towards other healers are discussed.

Perceptions of People on Health and the Causes of Illness

The perception of people on the causes of fitness and illness in the third world or less advanced societies is somehow similar, whether that is in Latin American or African or Asian society. Bishaw (1991) notes that healing in Ethiopian traditional medicine is more than curing of disease. It involves protection and promotion of human physical, spiritual, and material happiness. Bishaw says that since illness and other personal misfortunes are often perceived as resulting from a combination of "natural" and

"supernatural" causes, the diagnostic and therapeutic strategies employed are both "empirical" and "spiritual" at the same time. Therapy involves three fundamental strategies, comprising the manipulation of the patient's body, expelling or counteracting the factor or agent responsible for the illness, and getting rid of or appeasing evil spirits (p. 194). Hyolmos also believe that illness or any misfortune results from both natural (empirical) and supernatural (spiritual) cause.

Subedi (1989) surveyed consulting different types of healers and use of different therapies during the course of their illness episodes. He concluded that most individuals followed a specific pattern of behavior. When people experience an illness or a health problem, they would first consult their families and friends and they would attempt to self-medicate, usually with home or herbal remedies. If their health problem persisted they would consult the indigenous or local healers such as a shaman or a Buddhist Lama. If they still continued to experience problems they would consult a Western-trained medical professional, but this becomes only the last resort.

All Hyolmos have somehow similar social, cultural and religious practices. They live in a single geographical territory having the same climate. But the perception of each individual about health and illness was found different. Basically, the perception about the causes of illness is guided by age, sex and education. Because of the differences in these factors, people's perceptions differ. Every Hyolmo has the unanimous belief that soul and body are different things. Soul never dies but the body dies. Soul changes into air after the death of body and later takes birth in some new body. Soul remains always holy.

Hyolmos believe that health is the condition of active life and healthy people are those who do not have any health problem. Some of the locals believe that a fat man is a healthy man, but now this concept is changing when some fat man was caught by different diseases. They claim that the diseases developed in the physical body make a person ill.

As noted by Beine (2001), Hyolmos categorize illness into two major types: major (*Thulo*) and minor (*Sano*) illness. The illnesses which cannot be cured in the locality are called major illness. They include cancer, T.B., leprosy, bone fracture, blood pressure, asthma, chronic joint pain, AIDS, paralysis, ulcer, and surgery. Minor illnesses

are those which can be cured locally by any healing practices in a short period of time in low cost, such as cold, cough, fever, diarrhea, headache, body ache stomachache, minor wound, vomiting, joint pain, gastric problem, etc. An informant who has up to high school education said, "Some major illnesses like TB has become minor illness due to the regular treatment, whereas a minor illness can also be a major one if it becomes chronic problem". In this way, major or minor illness is defined in terms of the people's perception regarding treatment efficacy.

Feierman (1981) provided taxonomy of five categories of traditional causes of disease as observed by the people of north-eastern Tanzania. The first category is "an illness of (brought by) God," as opposed to "illness of man" which is brought by sorcery, and "simply happen, with no moral cause." The causation of illness of God comes close in its implications to the English term "natural," meaning "related to general principles of the behavior of things, as opposed to the artificial intervention of one's fellow men or women" (p. 355). The second category of causes is that of illness which people bring upon themselves through accident or neglect, but not through ill-will or sorcery. A malnourished child will be seen as an example of neglect. People view the care of clinic aides who inadequately clean hypodermic or blunt needles as the cause of abscesses. The third category is sorcery. There are various forms of sorcery and those ensorcelled will describe the type they believe they have been subjected to. The fourth is a number of different spirits, including nature spirits and those created by sorcery. The final set of the causes of illness are the acts of the individual's moral will, other than sorcery. The most important of these are the oaths taken falsely, which make a person sick. Offiong (1991) added "fate" as another category of the causes of illness.

Diseases do not attack equally to all people. An informant shares, "Illness depends on body (*bimar sarir guna hunchha*). Persons have high or low immunity power. Those who have low immunity power are caught by any illness faster. Illness is also caused by the lack of enough rest. Over load of work also causes illness".

Hyolmos believe that many factors cause illness in their local community. Physical weakness is a cause of illness. Physically weak people have to face many health problems. They become victimized faster by communicable diseases. Weakness is also caused by personal behavior. In one of the focus groups, an interesting answer was given

regarding the causes of physical weakness. One of the informants, after much discussion, explained,

> Weakness is invited by persons themselves using much alcohol, smoking or their negligence in health behavior. Generally uneducated people neglect more in their health which causes illness. The aged and females are physically weak compared to the young and males. The next cause of illness is imbalanced climate and imbalanced food. The imbalanced climate is the cause of illness, either by extreme hot or by extreme cold.

It is necessary to keep inner balance because the imbalance between hot or cold can cause illness. The participants of focus group discussion concluded that people of Melamchi Ghyang suffer more in cold and they need to balance their body using hot food items. They stated that cold diarrhea, common cold and cough, joint pain, etc., are the common health problems. Lack of balance in food items and the timing to take food also cause illness. Energy-giving fresh food items at proper times are to be used. They use organic local production in time to get rid of illness.

Old informants having no formal education pointed out that illness is caused by their bad deeds (*karma ko fal*). They believe that leprosy and TB are the result of their bad deeds (sin) of their previous lives. They also argue that evil power like *Masan*, *Naag*, *sindi*, *pichas* etc. cause people's illness. *Dhami/Jhankris* can satisfy them by offering the things they require. But the new generations are not ready to accept such argument. They claim that it is just a superstition. The villagers having formal and non-formal education are aware of their health and they know that illness is also caused by transmission. They know that the diseases like TB, common cold, cough, AIDS, diarrhea, jaundice, etc., are transmissible diseases. They attack physically weak persons faster. They are transmitted by sharing the same cloth, bed, food and air. The aware people try to stay away from such ill persons.

Besides, the germs in food items also cause illness. Mainly, it results in stomachache. Fear and worry bring illness. Mental stress reduces appetite and makes a person thin and weak. Hyolmos shared these experiences about the causes of illnesses.

Health-seeking priorities of the household heads. When a person becomes ill, he tries to seek competent health service providers of his access. The choice of healers is

mainly determined on the basis of the people's perception. Perception on different healers and their practices involves direct experience gained by the health seeker through various sense organs such as what they have seen, heard, felt or experienced directly or indirectly. Based on the locals' perception, the health seeking priorities and behavior towards health service providers is determined.

Table 15: ***Health-Seeking Priorities of the Household Heads for Themselves and their Members***

Priority	Hospital		Health Post		Lama		*Dhami/ Jhankris*		Self-medication	
	HH Head	%	HH Head	%	HH Head	%	HH Head	%	HH Head	%[5]
First	5	5.20	45	46.87	10	10.41	22	22.91	51	53.12
Second	22	22.91	21	21.87	6	6.25	24	25	-	-
Third	37	38.54	1	1.04	3	3.12	3	3.12	-	-
Total	64	66.66	67	69.79	19	19.79	49	51.04	51	53.12

Source: Fieldwork 2014

Table 15 shows that 53.12 percent HH heads medicate on their own first when they are ill because they claimed that self-medication is easy and not much expensive in case of home remedies. They are made by locally available medicinal materials. Altogether 46.87 percent HH heads choose health post at first. After the health post was established in the village and started to serve in a very nominal charge (Rs. 100 per person for check up and medicine annually), the ratio of health post followers increased. It is also the result of increment in literacy rate. Also, 22.91 percent people chose *Dhami/Jhankris* as the first priority. The informants who chose *Dhami/Jhankris* as the first priority were basically older generation who have not got school education and they claim that there are many illnesses such as *lagu, sindi, masan* which can be cured only by *Jhankris*. They also stated that *Jhankris* are pioneer healers for ailments for which there were no alternatives. Additionally, 10.14 percent preferred Lamaism as the first choice in illness.

[5] The percentage of responses exceeds 100 because of multiple responses about their health seeking priorities. The number of respondents also exceeds the total items due to their involvement in more than one practice. Health seeking destinations sometimes overlap. The patients consult more than one healer at the same time.

Lamaism is basically a more preventive measure, and the locals go to Lama for worshipping different forms of god. Only 5.20 percent respondents chose hospital as a first strategy. The nearest hospital is in Melamchi bazaar about 40 km far from the village; or they need to go to Kathmandu. Most of the people think that there is no need to go to hospital in the beginning of illness. They think that only in referral cases do they need to go to hospital unconditionally. Moreover, taking patients to hospital is a burden economically, and it is time consuming as well. Only those who have easy access to Kathmandu take the patients to city hospitals.

When their first attempt fails, they choose the next alternative as the second priority. Self-medication is found nil as the second attempt. Those who choose self-medication in the first stage are diverted towards other sectors in the second stage. About 25 percent of informants preferred *Dhami/Jhankris* as a second priority. It is a little increased ratio because some patients were also found going to *Jhankris* even after consulting health post when they do not get recovery. Next, 22.91 percent prefer modern hospital and 21.87 percent locals prioritize health post, after feeling that the case is serious. Only 6.25 percent people go to Lama in the decreasing ratio. If the second attempt does not succeed, they attempt the next option for the final hope: 38.58 percent people go to hospital, 3.12 percent each go to Lama and *Jhankris* and 1.04 percent people go to health post for final attempt. People are more likely to get recovery in the first or the second attempt; this explains the small population going to the third stage.

Regarding popularity of different service providers, the most popular is health post (69.70 percent), the second is hospital with 66.66 percent, self-medication comes in the third position with 53.12 percent, the forth is *Dhami/Jhankris* with 51.04 percent and the last is Lamaism with 19.79 percent (see Table 15). It clearly shows that the people who use allopathic medicine are in increasing ratio and the people who choose traditional healers are in decreasing ratio.

The interesting fact that Table 15 depicts is that all the health service providers except the hospital are in decreasing ratio in the second and the third priority, but people who choose hospital are increasing. That implies people have the final hope on hospital, though there is no hospital in the local area; they have to go to Melamchi Bazaar or Kathmandu city. Obviously, self-medication cannot be the second or the final attempt.

These above figures indicate the perception of locals on each healer and healing practice. The qualitative information about the people's perception on these healers and healing practices obtained from in-depth interview and focus group discussion are discussed below.

Perception of People towards Major Service Providers

There are different categories of healers to heal different health problems. People of particular health problem choose particular health services. People's perception towards the major health service providers in Melamchi Ghyang are discussed in the following sub-headings.

Perception towards health post. Health post symbolizes the modern, biomedical or allopathic service provider. Pigg (1995, 1996) discusses the role of Western medicine amongst her informants. Pigg's population was using Western medicine with increasing frequency. According to her results, informants associated Western medicine with development, education, and modernity. The perceived efficacy of Western medicine also appealed to them. This caused many of her informants to actively question the legitimacy of more traditional, indigenous forms of healing.

In one of the focus group discussions with villagers conducted in the local *chautara*, the participants concluded after a long discussion that their first priority was health post, second was *Jhankris* and the final was the hospital of Kathmandu. Health post service is prioritized by mainly the young people who are familiar with school education. The local school and adult literacy classes have contributed more to make positive perceptions towards health post. A local informant having formal education shares about the importance of local Health Post,

> We have to go nowhere other than village for health post service. It is well equipped with modern tools needed for basic treatment. It is cheaper as well. Doctors also come here occasionally to treat major cases. This practice is more scientific than others. Therefore, we think health post service is better than any other healing practices. After the establishment of health post, locals have got a big facility in health sector. It also has changed their health behavior**.**

When asked about what is to be done to the cases of any serious illness which the local health post cannot treat, he further adds,

> If such (major) illness happens during the doctors' visit, they treat using the medicine and equipment, and they refer to the more facilitated hospitals. The nurse of the health post also refers to the other hospitals in serious cases. We people like to go to the hospitals of city area, mainly Kathmandu, because we must pay hospital charge wherever we go and we go to Kathmandu to assure the solution of health problem than the hospital of Melamchi Bazaar. There is no remarkable impact by the establishment of hospital in Melamchi Bazaar. In addition, accommodation is easy in Kathmandu than in Melamchi Bazaar.

Although many locals have positive perception towards the health post, some old and those less aware about health have negative perception toward health post or allopathic practice. One of the locals asserted in an interview, "Health post service is not very effective. Nurse is immature and has only a little knowledge. She provides only Cetamol (paracetamol) in each illness episode". Another informant added, "People have the belief that allopathic medicine increases illness if the case is caused by evil spirit (*lagu*)".

In the mean time, another informant, who is a political activist and the local businessman, reported,

> I do not like to use allopathic medicine because it has side effects on one hand and the dose may increase in the next attempt and the problem may recur on the other hand. The local herbal medicine does not work when we start to use allopathic medicine. I do not prefer health post; rather I prefer herbal medicine available in local area in minor cases.

It shows the contrary ideology between allopathy and herbal treatment. He claims allopathy has the side effects, but the staff nurse of the local health post claims, "None of the people have come to the health post complaining of the side effect of allopathic medicine so far".

Whatever their reports, many of them have strong belief and positive perception toward health post service. I have observed that five to seven patients of different cases go to health post daily.

Perception towards *Dhami/Jhankris.* *Dhami/Jhankris* are commonly named as *Jhankri* alone or *Bhombo* in Hyolmo language. They are the traditional healers healing

the ill person from time immemorial. They occupy the fourth priority for healing after health post in Melamchi Ghyang (see Table 15). The villagers believe that the illness caused by evil spirit (*lagu*) like *sindi*, *masan*, witchcraft, etc., cannot be treated by health service providers other than the *Jhankris.*

The people of older generation, basically the illiterate people, were found to have a positive perception of *Jhankris*. A teacher of the local school shared, "The first healing practice is *Jhankri* mainly in the households where there are old aged people". This practice is popular in the events of illness in which the symptoms appear at once. One of the informants shared, "*Bhombos* are appropriate in healing process when the person feels headache, heart pain, fever, vomiting, dizziness or fainting at once".

Wongdi Dorje Hyolmo, a teacher, claims that the first priority is *Bhombo* in many cases of illness. Therefore, they are the respected persons in Hyolmo community. Yongjen Lama, 66, a woman, said, "I believe on *Bhombos*, they save the life of almost dead patients". Meanwhile, another woman, Pema Buddhi Hyolmo, 35, said, "I got a serious problem of ribs pain and went to hospital at Kathmandu but could not get well. Later, a local *Bhombo* healed and made me well. So I believe them".

Despite the contributions of *Jhankris* in health service from the past, many villagers share that only a few people go to them. Their number is also decreasing. This statement is also accepted by local *Jhankris*. Pasang Bhombo, a local *Jhankri*, accepts that both the number of *Jhankris* and their followers are decreasing. The next *Jhankri* Kami Lama said, "The culture of going to *Jhankris* for health recovery is declining with the establishment of health post and school. We (*Bhombos*) are not in the priority of villagers". It is due to the availability of reliable medical alternatives and nthat many young people have not much positive perception towards *Jhankris,* as they believe that shamanism is just superstition.

Kamal Basnet, a local businessman residing in Melamchi Ghyang for more than two decades, shared that many villagers have to face the case of untimely demise while trusting on *Jhankris*. Sometimes they tell lie. He further adds,

> Once, my son got ill when he had gone to Melamchi River, near Chanaute bazaar, to collect sand for the construction of toilet. Local *Bhombos* claimed that the son was caught by *sindi* and *Black masan.* He became further serious when local *Bhombos*

applied *mantra*. Next morning I took him to the hospital at Kathmandu. Actually he was suffering from typhoid. A whole week was spent for his full recovery.

This is one of the events by which the trust towards *Bhombo* decreased. Indra Dev Yadav, a teacher of local school residing in this area for more than two decades, shared a similar event:

> About 10 years ago, an old *mheme* (respected male person) got ill and did not get well even after the strong effort of *Bhombos* and finally he passed away. He was not much old. Had he been taken to hospital on time, he would have lived longer. Due to the poor economic condition and lack of awareness, his life ended even with minor illness. Now I also suggest going to hospital if recovery is not possible by *Bhombos*, and they follow my suggestion. People used to depend fully on *Bhombos* in the past. Now people follow *Bhombos* only for initial treatment.

An FGD participant in a mothers group shared about a saying of a *Jhankris* to the evil spirits: "*Aaja jau jau, Voli aau aau, Ta naaye ma ke khaun?"* It means, "Go for today, come again tomorrow. If you don't attack, what I eat?" It is the common saying of villagers about *Jhankris*, which clarifies the perception of villagers towards *Jhankris*. She further reported by laughing, "If *Bhombos* disappear, illness also disappears". Interestingly, one of the informants wished to increase the number of *Jhankris* because he claimed that all the unseen evil forces can be controlled only by *Bhombos*, but many of the informants said that *Jhankris* speak lie and patient dies untimely. In this way more negative perception towards *Jhankris* was found among the villagers.

Perception towards Lama. Lamas are the most respected persons in Melamchi Ghyang (see Table 8). It justifies that people have the highest degree of positive perception on Lamas. They are the skilled people who are social and religious leaders. They perform more religious activities than healing. They follow preventive measures of healing. They pray, meditate and perform *puja* with lamp, incense and other materials, wishing for the collective welfare of society. They also wish for good days. They observe the planetary condition and their effect on individuals. They try to reduce their negative effect through worshipping.

Kami Lama, a renowned social worker of Melamchi Ghyang, says,

> There are few educated Lamas in our village. Lamas can predict future and find good or bad days. The bad days are removed by their god power. They are the most important persons in every ritual. They perform the process of purification of spirit in death rituals and stop turning the spirit into *sindi* (an evil spirit). They find the good time (omen) before the beginning of any new task, such as making home, wedding or travel a long distance. They worship in Gumba in the time of Lhosar and make us prosperous. Therefore, Lamas are valued the most in this community.

Buddhist Hyolmos believe that Lamas have adopted divine power that they use for collective welfare of the community. Everyone has strong trust and respect towards Lamas. Interestingly, none of the respondents criticized Lamas. It justifies the positive perception of villagers towards Lamas and Lamaism.

Perception towards *Aamchi.* There is a single *Aamchi* in Helambu and not found in Melamchi Ghyang, but all people are familiar with *Aamchi* practice because *Aamchi* comes to their village occasionally. People have strong belief over this practice mainly to treat the problem of jaundice. One of the informants shared about *Aamchi*,

> *Aamchis* are actually professional herbalists. They learn the healing idea from Tibetan book. They are learnt and wise persons. They can also heal the new diseases with the help of the textbook. They are good healers, but unfortunately they are not here. A single *Aamchi* of Nakote (next village) cannot solve the health problem of all the people of this locality and each and every disease, though he is good at his profession. Some villagers find *Aamchi* in Kathmandu and treat. I have also been treated by *Aamchi* in Kathmandu.

Many other informants had similar perception on *Aamchi*. Everyone has positive perception towards *Aamchi*, but their absence in the local village is a big problem. Therefore, the villagers do not fully depend on *Aamchi*. Instead, they try to find other effective alternatives for healing.

The local *Aamchi* himself remarks,

> Many of the medicines which I provide are already tested by many people and many times. Some medicines for new diseases are under test. I can treat the patient of sugar (diabetes), jaundice, snakebite, poison and many problems with

guarantee. The old followers and the new clients are equally increasing. I am fully satisfied with this job.

Local people's voice and *Aamchi*'s saying was found co-related. So, the villagers have positive perception towards *Aamchi*.

Perception towards herbal practice and self-medication. Herbal practice is a traditional healing practice next to *Dhami/Jhankris*. Many villagers agree that herbal practice was popular before the establishment of health post. It is still used by the locals in a small scale. A very few old villagers know the herbs and their uses. *Kutki* is a very familiar herb to all villagers, which is used to treat fever, cold and cough. This practice decreased when Langtang National Park captured their local jungle area. Community forest users group also controlled the collection of herbs from the jungle. Transhumant herding practice, which made it easy to collect herbs, is also decreasing rapidly now. The common medicines are available in local health post. Therefore, herbal practice is decreasing rapidly.

I found that people have positive perception towards herbal practice. It was historically practiced and accepted, which is supported by the following statement. A 48-year-old woman named Jhangmu Sherpa reported,

> Herbal medicine is our culture. We use various herbs for various illnesses. It has no side effect. It is cheap and tension-free to use, as it is found in local surroundings. It is an effective practice in many health problems. But now only a few people recognize the herbs and their uses for different illnesses. People who know about it neither teach the young generation nor the new generation wants to learn about herbal medicine. Therefore, this practice is decreasing.

The local herbalists are not open to teach their ideas. They believe that the idea should not be disclosed and made familiar to everyone. The new generations do not like to learn this idea because they are facilitated by the medicine of health post and do not like to take tension on it.

Lopsang Lama, a local social activist, also agrees with this statement and adds more,

> Hyolmo region is the storehouse of many herbs, but we are neither familiar with the herbs nor have utilized them. Hundreds of herbs, including *yarsagumba*, are

found in the local jungle. Many of valuable herbs are found in altitude above 4,000 meters, but who goes to collect? We have to protect this practice because it is our cultural identify.

Some people have shown less interest on herbal practice. One of the young informants shared that herbal medication provides slow recovery but people want fast recovery, so they prefer to go to health post. Another informant added that herbal practice is done without the diagnosis of illness and sometimes becomes more complicated while using herbs. The next informant questioned, "Why bear the trouble of collection and making medicine from herbs if we get the readymade medicine in health post?" And the next informant said,

> Who knows herbs and their uses? The early people had strong idea about many kinds of herbs, now they are no more. The cow herders used to bring herbs in village when there were cow sheds (*chauri goth*) in the forest. Now, there are no people to collect herbs. Great medicines (*Maha Ausadhi*) are also found if searched properly.

Though people have positive perception, this practice is decreasing. Self-medication is very popular in the community. The initial treatment begins with self-medication: 53.12 percent locals first use self-medication in every health problem (see Table 15). Self-medication includes herbal practice too. Hot water and hot alcohol is commonly used in the problem of cold and cough, as Melamchi Ghyang is a cold place.

Wherever they go for healing, initial treatment is done using self-medication. Now, a new form of self-medication is to take medicine by family members from health post or to buy medicine from the medicals of the city and to take to village.

The staff nurse of the local health post also accepts that self-medication is widely prevalent in Hyolmo region. She agrees,

> Both the herbal and allopathic medicines are used for self-medication. A few people come to health post to take medicine for their family member who is unable to attend. They explain the symptoms and I provide medicine. But the patients themselves come here as health post is in the centre of the village.

When I asked the villagers to find the reasons of self-medication through health post, most of the villagers gave the same response that it is the easy way to be tension-

free from illness as they do not have to go to anywhere for medication. One of the informants shared,

> No doctors (medical experts) are there for checkup nearby. Hospital is also not near the village and home remedies are effective. Proper checkup is necessary if people suffer from major disease (*thulo rog*). Self-medication is useful for any minor illnesses. This practice is easier, cheaper, and effective as well, so Hyolmos are practicing from the time immemorial.

No informant spoke against self-medication. The medication using allopathic medicine seems to be increasing nowadays after the establishment of health post. Interestingly, people's habits were found to use medicine rather than to check it up first.

Healers' Perceptions towards Other Healers

Like villagers' perception towards different healers, the perception of healers towards other healers was also found to be one of the factors determining the choice of medical practices. Some of the healers have positive perception and some others have negative perception, which is clearly found in their behavior and referral process when an illness becomes further complicated. The healers have different perceptions towards other healers in Melamchi Ghyang. Generally, all healing practitioners are positive towards other healers and they also co-operate one another. Their aim is to make the villagers free from illness, but there is a strong question about their existence. I have also found a competitive feeling among them, which sometimes creates conflict.

There are two distinct types of healers: traditional and modern. *Dhami/Jhankris*, *Aamchi*, herbalists, Lamas, and ethnomedical practitioners are included under traditional healers; and allopathic practitioners, mainly health post and hospitals, are under modern medical practitioners.

Dhami/Jhankris treat bodily illness (*lagu*). They are the first healers in the community. Now, they are gradually replaced by allopathic practitioners. They have a contradictory feeling: that they are satisfied themselves by their profession on the one hand, but they do not suggest others to become *Jhankri* on the other hand. They do not suggest even their sons to become *Jhankri* because they claim that it is not a lucrative job, and it is just a social service. They have to be ready to heal at any time, even at midnight.

A *Jhankri* shares his feeling about shamanism in this way,

> I began to work as *Bhombo* from my childhood. It was a great job at that time. People from other village also used to invite me very often. There were no healers other than *Bhombo*. We did in our time. Now the situation has changed, but we cannot change our job. I am getting old too, my life has gone. But what will be the future of this practice, I cannot say.

When the health problem of a patient increases, *Jhankris* often refer patients to go to senior (*thulo*) *Jhankris.* If senior *Jhankris* of the village cannot solve the problem, they refer to the *Jhankris* of Ghyangfedi and Kulu, Nuwakot. But an informant shared that the healers have a feeling of competition with each other. One *Jhankri* does not address the next, thinking that he is the only superior. I found two *Jhankris* in an event of death ritual in Gumba. One of them denied taking interview at first, and when I started interview with the second one, took photograph and discussed about his healing procedure for hours, the other *Jhankri* not only became ready for interview but also told me secretly that the first one was not the real *Jhankri*. He said, "He (the next) is not a real *Jhankri,* he has no idea about *mantra*. He is doing just a fake work. People do not have belief over him". He further tried to establish himself as a real *Jhankri* in front of me, "My forefathers also were *Jhankris*. It is our job from the long past. I can treat any illness. Every villager has belief over my healing". An informant shared secretly when I assured not to publish his name, "Sometimes the situation of conflict comes between *Bhombos*. They rarely attack physically to each other. It is due to the proud feeling that one is more powerful than the next. Hence one does not count the other".

When I asked the villagers about the efficacy of healers, the villages responded that particular types of illnesses are more effectively cured by particular healers. Local people have enough experience on where to go for what health problem. For instance, they believe that *Dhamis/Jhankris* are more effective for the illnesses caused by evil forces. Traditional healers cannot solve each problem equally. Co-incidentally, one of them may be more effective for one patient and another patient may feel the other *Jhankri* more effective. All the *Jhankris* had unanimous voice that the other *Jhankri* heals if one *Jhankri* becomes ill. To heal self is not effective. This shows that *Jhankris* have the feeling of both conflict and cooperation among them. The local *Jhankris* claim that they

also refer to health post mainly in cases of accident, wound and fever. In a focus group discussion with schools teachers, they also supported the claim of *Jhankris.* But interestingly, the nurse of local health post shared that no *Jhankri* has come to health post to treat for them so far.

Informants shared that shamanism is practiced even inside the hospital when a patient is admitted in hospital of Kathmandu. They took the name of some hospitals where Hyolmos mostly go for treatment and claimed that *Jhankris* are invited to heal the patient admitted to hospital. When I asked about the responses of hospital administrators and doctors, they shared that they go to heal there when there are no doctors, but hospital administrators indirectly support them by ignoring these activities. It proves not only the relationship between hospital and *Jhankris* but also that Hyolmo people have a strong belief towards both service providers.

Jhankris were found positive towards Lama. Both are traditional healers but their nature of healing is different. Lamas are basically religious healers whereas *Jhankris* are spiritual healers. A local *Jhankri* shared about the recognition of Lama,

> We need Lama in every ritual. They adopt preventive measures of healing, which is necessary for us too. They pray for all the villagers. They help to bring good days. We respect them for their social service. They are the important persons for our society. Sometimes we also consult them in illness and to remove bad days.

Similar versions are found in all *Jhankris* when they are interviewed. This clarifies that *Jhankris* have positive perception on Lamas.

> Being limited in number in the Hyolmo region, there is less impact of *Aamchi* on villagers and on *Jhankris*. A *Jhankri* says, "*Aamchi* is doing his own job, serving the people, and it is good for us". When I asked the *Jhankri* about the possibility of decreasing the number of their clients due to *Aamchi,* he said. "It is the interest of people to go anywhere. It depends on the patients and their family about where to go. If they like *Aamchi* they can go, or if they like me they can come to me. It is the freedom of the client. The next thing is that *Aamchi* should also live by his job".

Another *Jhankri* also shared similar response towards *Aamchi*, which proves that there is no negative relation with *Aamchi,* nor is the relation strongly positive. But rather, *Jhankris* ignored the service of *Aamchi.*

Jhankris have positive relation and responses towards the local herbalist. They said that herbal productions are needed for them too. Sometimes *Jhankris* also give herbs to patients while healing. It was observed that a *Jhankri* applied not only *mantra* but also a medicinal herb during his healing practice.

Lamas are the religious leaders under Buddhism. As Hyolmos are Buddhist followers, Lama is their ideal person. Without his role, each ritual becomes incomplete. Actually, Lama plays the role of guardian in the society. They perceive every healing process positively. They define health and illness with the impact of god power. Illness is caused when the god becomes unhappy, and the only source of getting healthy life is to please them through right action, mainly truth and non-violence.

Tenjing Lama, the renowned local Lama of Melamchi Ghyang, presents his perception:

> *Bhombos* are serving traditionally in our community since when there were no any alternative healers. Still many villagers have strong belief over *Bhombos.* Particular illnesses—mainly mental problem, witchcraft, fainting, vomiting and the problems caused by bad spirits like *sindi*—are solved only by them. Though the local herbalists and *Aamchis* are few in number, they utilize local herbs and protect the indigenous knowledge while healing the patient. Actually they are great.

In case of allopathic practitioners, mainly health post and hospital, he expressed his perception in this way,

> I have not done curative treatment so far but my family members go to health post. Actually health post has supported all other healers' task. Health post service is useful for pregnancy, delivery, cut, wound, immunization, etc. In this scientific age, we must follow the scientific practice. Surgery is impossible from healers other than hospital. Nowadays, the case of surgery is increasing. It would be impossible without hospital. Allopathic practice has saved the life of many people.

Lama seems positive to all healing practices, and he focuses on the existence of all the practices in cooperative way: "Coexistence of all healing practices only can make better health of our community people".

Aamchi is also positive towards all the other healing practices. He reports,

> The healers do the things what they know and the followers also follow according to their interest. Those who like my healing come to me. I do not mind those who do not come to me. I think people believe in my healing as the number of followers is increasing day by day. I have nothing to say to any other healers.

Aamchi also shows the feeling of cooperation and stresses on the coexistence of all sorts of healers. In serious cases which needs referral, he reports,

> I am happy on the establishment of health post. In some cases I refer to health post and hospital when the medicine which I provide will not be effective. But there are rare cases of referral because of my effective treatment. Generally I do not refer to *Bhombo*, but if patients like they can go anywhere. I think modern healers are more effective than the traditional healers because they use tested medicine and equipment.

Aamchi and herbalist both use herbal medicine, but their source of knowledge is different. Herbalists use herbs based on their experience and the knowledge transferred from generations to generation, whereas *Aamchi* uses the same source of medicine by studying the Tibetan book. Herbalists also do not have any comment on any other healers like *Aamchi.* Their worry is only on the loss of their indigenous knowledge about the idea of medicinal herbs and their uses.

Allopathic healing is the most popular healing practice in Melamchi Ghyang since the establishment of health post. About half a dozen patients go to health post daily to get any sort of health solution. The number of patients further increases in the cold season.

The health post in-charge reported:

> All people come to treat in health post except for Lama and *Jhankris* themselves. It is the consumer's choice about where to go for treatment. I refer to the next health post of Kharchung or Melamchi Hospital below or the hospitals of Kathmandu in serious illnesses. Recently, a patient of bone fracture was referred.

But I do not refer to any traditional healers because most of them, mainly *Jhankris,* are superstitious.

Pigg (1996) states, shamanism is a controversial subject, especially amongst and within the minds of Western health care providers. The health post in-charge is not much positive towards *Jhankris* (shamans) because she claims, "Many patients come on the eleventh hour in health post as they try to heal for a long time with *Jhankris* and do not get recovery". Generally allopathic healers do not care about other healing practices, but sometimes they are in problem because of other healers who apply meaningless effort to heal the patient but the case worsens.

Summary

Health seeking behavior is determined by various factors such as belief, knowledge, tradition and culture, and socio-economic background. It is also guided by the efficacy of health care services that the consumers evaluate. It also depends on the nature of illness because all sorts of illness are not cured by all health service providers. The major determining factor of health seeking behavior of the people is their perception towards different healers. They go to the healers with whom they have constructed positive perceptions.

Hyolmos think that there are natural and supernatural causes of illness. Natural causes include physical, environmental or climatic cause, food habit, etc., and supernatural cause means the illness caused by spirit, evil power or god. Whatever the cause of illness, they try to seek effective healers. The villagers are more likely to prioritize self-medication as the first and health post as the second option for seeking treatment almost with the same ratio of population. And their final destination of treatment in major case is hospital. The cases of the final appointment with *Dhami/Jhankris*, Lama and the local health post were found rare.

Many people have very positive perception toward the local health post because of regular and effective treatment. The frequent doctor visits, by which the major cases can also be solved, and its low cost have made the people more positive besides its effective service. The allopathic healers' perception towards other healers was found positive, but they are not much positive towards *Dhami/Jhankris* as they worsen the cases by delay.

Dhami/Jhankris are also the respected persons in the community who treat the illness caused mainly by the spiritual and evil power. Local people have both positive and negative perception towards *Jhankris***.** Young generations and aware people do not prioritize them, whereas old generations still have a strong belief in them. *Jhankris* have positive perception with other *Jhankris* as they refer to the senior *Jhankris* in serious cases, but sometimes they have ego problem and feelings of competition and conflict among local *Jhankris* due to pride in their knowledge. They feel positive towards *Aamchi*, Lama and herbalist but do not seem much positive towards the health post. They did not oppose health post service openly but showed some degree of dissatisfaction.

Lama, *Aamchi*, and herbalist have got positive response by all the villagers despite of their inadequacy in healing practices. Lamas are very positive to all healers and people, so are the *Aamchi* and herbalist.

CHAPTER VII:
CHANGES ON MEDICAL CHOICES AND THE FACTORS CONTRIBUTING TO THE CHANGE

Change is a continuous process. Despite the barriers, changes occur in society. Sometimes we observe revolutionary changes and sometimes changes occur slowly in the society. In the process of social change, medical and healing practices also cannot remain constant. Many changes are observed in Hyolmo people regarding their medical choices and healing practices. These changes are clearly observed in the last quarter of a century. Many factors have played significant role for the changes in their entire lifestyle in recent decades. Medical or healing practice also could not remain far from the changes. In this chapter, the changes related to healing practices and factors contributing to the change are presented and analyzed.

Talking about the medical practice in the past, Bishop (1998) states,

> In 1970-71, residents of Melamchi only occasionally sought medical advice in Kathmandu. Seeking medical treatment from hospital in the city means they needed time to be away from the village and work, the necessity of cash payment and lack of familiarity with the Nepali language. This meant most people having illnesses were dealt within the village. The distance and terrain were other impediments. Without road and helicopters, people had to be carried on the back of others which was extremely uncomfortable for everyone involved… General people used home remedies. (p. 128)

Now they have good link with Kathmandu. There is road transport and health post facility. Those have brought remarkable changes in medical practices.

Frackenberg and Leeson (1976), Feierman (1981), and Young (1981) describe the systems model to analyze the impact of social forces on the search for health care. This model, according to Janzen (1978), requires two levels of analysis: one at the micro level (incorporating perceptions about an illness, its prevalence, and efforts to diagnose, prevent, and cure) and one at the macro level (incorporating information about large-scale social entities such as health institutions, economic and political systems that dictate access to health care). In my study, I have used both levels of analysis, focusing more on micro level.

The traditional life style of Hyolmos guided them to explore and use herbal medical practice, but when their lifestyle shifted into modernity from animal husbandry, their medical practices also shifted towards allopathy. The two case studies below in the box clarify this transition.

Case Study 6: A Model of Transhumant Herding: Cow Shed at Palungkharka

Until three decades ago, all the households practiced transhumant herding in Melamchi Ghyang. Naomi Bishop (1998) wrote a book and also made a documentary named 'Himalayan Herders' on this issue. They used to keep yak, *chauri* (*Zomo* in local language, hybrid of yak and cow that provides milk more than cows), cows and sheep and shifted their shed from place to place in the grassland of jungle. When people were asked about their birth place, many informants aged above 30 years answered that they were born in cows/yaks shed, and informants below 25 years answered that they were born in different parts of India. It proves that 1980s was the transitional period for Hyolmos to shift from animal rearing to abroad work.

Now 30 HHs have cows and oxen, 6 HHs have buffalos kept in their house. They do not change the place. But still three yak sheds and three *chauri* sheds are in the jungle. I had observed one yak and one *chauri* shed in the jungle during my fieldwork. This is the interesting real story of traditional lifestyle.

One chauri *gode* was in Palungkharka, about 5 km below the Melamchi Ghyang, and one yak shed was in Ghyangkharka, about 7 km above Melamchi Ghyang. It was in winter (January/February) when the sheds were transferred to the lowest altitude. Below that altitude, neither *chauri* nor yak can survive. Yak cannot survive in the lower altitude up to where *chauri* can survive. But the herders' lifestyle was similar in both sheds.

There was a shed (*goth*) made of bamboo mat built over poles with the plastic outer. Two dogs were in two sides of the shed. They were kept for security from the wild beasts. They barked much at the strangers (we people). I had gone there with my assistant and the local guide Kamal Basnet. There were 41 *chauris*, around 300 sheep, some goats and chicken. An old woman aged about 65 was there alone. There were a large number of animals. The owner herself could not tell the exact number of other animals except

chauri. There were pots to boil milk and to make ghee. The animals were in open space and they lived in open sky even at night. The shed was made for people only. All the animals were free, that is, they were not tied. There was really a traditional way of livelihood. The owner prepared tea and requested us to take *chamba (saatu)*.

After a while, dogs stopped barking and we started our talk with the owner. She shared, "Now I am alone here. One member of family comes for night to support. About 4 hours a day is spent for milk in the morning and evening. It is boiled and made curd and ghee. Cheese is also made occasionally. These products are for livelihood. The surplus products are sold in the village. Now, many villagers do not keep animals for milk. Sometimes the products are sold in the local market of the lower village and in Kathmandu. There are relatives in Kathmandu who manage to sell these products in the market."

When I asked about food habit, she shared, "The main food items are milk products. Flour is brought from home. Now I am near home. When we go up in summer, the food stuffs lasting four to five days are taken to the place. There will be crisis of food. Therefore, sometimes we live only by using milk product for days.

When I asked about the transhumant herding procedure, she replied, "A shed is kept in grassland for around 20 days to one month. When the grass is over, we have to shift to the next place. Sometimes another shed might have already finished the grass in the targeted place, and we have to shift to the next place."

Then I asked about health problems during the transhumant herding process and its solution. She shared, "We are healthy. There is no major health problem in us. If minor headache or cold attacks, we drink hot alcohol and hot milk or we use herbs found in the jungle. I know 9-10 herbs which are the most usual and necessary. I collect them and bring home.

A similar lifestyle was observed in the yak sheds of Ghyangkharka. It is the next example of transhumant herding. It represents not only the lifestyle they had been spending from the past, but also reflects the adjustment mechanism in cold environment and to fight against health problems along with the process of herb collection.

Case Study 7: A Model of Transhumant Herding: Yak Shed at Ghyangkharka

After a walk of about three hours from the village, we reached a yak shed at Ghyangkharka. There were three yaks and more than 25 cows. Yaks are 'man beaters' to strangers. They came to attack us, and the owner protected us. There was a young boy of about 16 years. He was kept as herder with the allowance of Rs. 15,000 per year. He has never gone to school but was clever to talk. The lifestyle of this shed owner was just like that of *chauri* shed owners. The only difference was that yak could not come down and yak shed owners had to go up earlier and *chauri* shed owners followed them. The yak owner is happy with his lifestyle. He claims, "I am healthy and spend simple life. I do not think that it is hard life. I produce milk and drink enough. The extra production is sold in Kathmandu, where my sister lives. It is a lucrative job as ghee and cheese are valuable products."

When asked about the process to protect from cold, he said, "We use tea and alcohol and also wear thick clothes". When I asked about the idea of medicinal herbs, he shared, "I recognize various medicinal herbs like *Panch aule, Ban Satuwa, Chiraito, Kutki* etc. *Yarsagumba* is also found in high altitude, but the national park does not allow us to collect them. We collect a few pieces of it secretly and give to villagers as gift. We do not sell them."

While talking about the satisfaction of life, he frouned his face and said, "I am satisfied but sons did not like to follow it. There is lack of manpower for animal rearing. Probably this process will be ended after my life". He has 3 sons but all of them have gone to India to work.

Finally, he requested me to drink tea, but soon it was going to be dark. I had to come back to Melamchi Ghyang. He was ready to show me the next shed. But unwillingly I denied both tea and going to the next shed because the next shed was at a distance of one hour from that shed. He knows the surrounding topography and the location of other pasture well.

Both the sheds were owned by the people of Melamchi Ghyang. The distance between the two sheds was more than one hour. They do not get any help immediately when

problem arises. But they do not feel any problem as they have already worshipped/prayed god to avoid such circumstances. Sometimes wild beasts attack the animals and kill, but they can do nothing. Next, they are in problem due to the continuous snowfall for a long duration when they are in the high altitude of some 5,000 meters.

Generally they do not suffer from any illnesses. Minor illness like cold cough and headache are solved by using herbal medicine. They have the idea about medicinal herbs. They collect a few herbs and bring to village. In one sense, they are the local herbal experts. Herbal practices in the village are continuing due to them.

Change in the local peoples' life style from transhumant herding has brought a big change in medical practices. Consequently, decreasing ratio of transhumant herding has decreased herbal and self-medication practices.

Melamchi Ghyang: A Timeline

Melamchi Ghyang has its own history based on local events, and it is influenced by some national events too. These events are directly associated with medical/healing choice and their changes. These events have influenced the efficacy of different healers in the local area. Therefore, a timeline related to the history of Melamchi Ghyang over the last five decades is drawn in table 16.

Table 16: ***Timeline of Melamchi Ghyang***

Dates in AD	**Major Events**	**Major Changes**
1950s	People went to work in Burma, Assam and Sikkim.	After the contact with outside cultures through out-migration; western medical practice began gradually
1960s	Circular migration to different cities of India accelerated.	Increase in awareness, allopathic medicine introduced, increase in economic well being
1976	Langtang National Park established.	Rumor of capturing pastureland by the expansion of national park and people started to shift in other works.
1980s	Chauri production started in local shed.	End of buying *chauris* in expensive rate from upper Rasuwa, increase economic strength
1982	The third Chiniya Lama died	End of the era of feudalism unofficially.
1986	Jungle of Melamchi Ghyang area incorporated in National park	Loss of autonomy on the control of jungle resources by the villagers, control in herbs collection
1987	Langtang Trekking route of Sundarijal,	Tourism accelerated, increase in allopathic

Dates in AD	Major Events	Major Changes
	Gosainkunda, Melamchi Ghyang opened	medicine, economic strength
1989	School established in local area	Helped to raise awareness in every sector including health and hygiene, socialization of children, raised allopathic practices
1990	Democracy restored in the country	Raised awareness in politics, increased link with other non-Hyolmos
1990	Electricity supplied to houses produced from local Phadung Khola	Increase in the facilities of the means of communication
1990s	Bombay returnee women brought AIDS	Awareness on HIV/AIDS and sexually transmitted diseases
2000s	Guthi Land began to change into Raikar	Freedom on land using, economic strength
2005	Community Action Nepal supported in health and education sector	Health facilities started, school got support
2007/8	Telephone and cell phone service	Easy communication with relatives living in city and Bazaar area, information about the availability of doctors in the Health Centers
2010/11	Disc home TV channel system began	Access to different channels and television programs
2011	Melamchi FM established in the area	Health program started to broadcast in radio, awareness increased
2011	Establishment of health post	Facilities of modern health service, allopathic medicine users accelerated
2012	Link with road transport	Offered different facilities such as food and medicine supply
2013	Local high school started 10+2 class	Access of higher education locally

Source: Fieldwork 2014

Education. Education is the key factor to change the society. Education gives awareness, and aware people have different attitudes toward medical choice**.** Since the establishment of Melamchi Ghyang School in 2045 B.S., literacy rate in the area changed from almost nil to 62 percent. Among the above six years aged population, 8.18 percent are SLC passed and 6.34 percent have passed up to intermediate (higher secondary) level. Five males (2 percent) have successfully completed bachelor's level too. Analyzing on the basis of sex, 74.5 percent males and 48.74 percent females are literate now (see Table 5). Adult literacy classes are going on continuously for four years. These classes have also contributed to increased literacy rate in the area.

Health education provides specific information on the best types of help and suggests how those types of help might be obtained. These things can have an important impact on the 'taking action' phase of the (behavioral change) process (Catania et al. 1990). Along with the increasing number of people with formal education, medical choices and priority also changed. A 78-year-old male informant shared that he has very little trust in *Dhami/Jhankris.* It clarifies that school has taught not only the students but also the guardians.

In a discussion, Mani Prasad Adhikari, the head teacher of Pema Chhyoling Lower Secondary School, Nakote, shared,

We refer first to local health post and then to Melamchi Hospital or to the hospitals of Kathmandu, depending on the seriousness of patients, but we never refer to *Dhami/Jhankris*. In the past, local people were ignorant and used alcohol in the case of fever or typhoid; as a result, many of them lost their lives. But now the situation has changed due to school education.

Other teachers I met and interacted with also shared similar opinion, claiming that they contributed to bring change in the medical practice of the community.

Some youths who study higher education in Kathmandu also have changed their and their family members' medical choice. The families, who depended on local shamans in the past, have started to go to health post or hospital for health seeking now. Education has contributed to decrease the status of *Dhami/Jhankris* and their followers. It has also helped to decrease the superstitious beliefs such as the tradition of sacrificing animals.

Transportation. As traffic increases between India and Melamchi, the health profile of the village will no doubt change. There are evidences of diseases that are encountered in India: measles, chicken pox and tuberculosis have all been implicated in death of Melamchi people in India (Bishop 1998). Timbu, the lower Helambu, was connected with road transport a decade ago. There is public bus facility regularly in all seasons. It is connected by graveled road because it is near the tunnel of Melamchi Drinking Water Supply Project for Kathmandu Valley. Melamchi Ghyang is about 75 km north-east from Kathmandu, connected by agricultural ungraveled road. The place was connected by the road in 2068 B.S. but cannot run transport regularly due to the worse road condition and lack of bridge over the Melamchi River. Thus, bus facilities are

limited only to winter season. Recently, the queue of public bus started this year, but there is no reliability of this facility.

I had met the surveyor, Sujan K.C., the overseer of a new highway which runs at higher altitude. He named the highway as 'Himali Highway' informally. During my fieldwork he stated,

> About 65 km from Kathmandu to Melamchi Ghyang, Himali Highway has been surveyed recently, which connects the places from Kathmandu to Melamchi Ghyang. The major places between Kathmandu to Melamchi Ghyang are Sundarijal, Chisapani, Pati Bhanjyang, Chitre, Golfu Bhyanjyang, Kutumsang, Mane Gaire, Nalumkharka, Tartung, Sarkathali and Melamchi Ghyang (Helambu).

If this highway is completed, it becomes the shorter route to arrive Kathmandu. It is the second alternative hope for the people of Helambu.

There are no facilities of transport other than the ungraveled road in Melamchi Ghyang. Helambu Sarokar Samittee has started ambulance service too, but the upper Hyolmos (people of Melamchi Ghyang) are not benefitted much by this service. Lanam Lama, a local political activist reported,

> Some rich people went to Kathmandu by helicopter charter with the heavy cost of around Rs. 75,000 in accidental case and serious illness, and such situation repeated 3 to 4 times a year. Poor people could not have such economic strength and the patients from their family were carried by people to Timbu Health Post and Melamchi Hospital. Now the situation is changing a bit due to transport facility.

Similar statement was given by other interviewees too. Now people can arrive in Kathmandu in a day if there is public bus facility. When I was going to field, I observed that some people were maintaining road in three different places on the way to Melamchi Ghyang. This is the single ray of hope in transport. The distance between Timbu (where there is the regular facility of transport) and Melamchi Ghyang is about five to six hours walk on foot.

Facility of road transport has started to bring change in their lifestyle. About 21 percent households use LP gas instead of firewood as fuel for cooking (see Annex Table

11). It has decreased the smoke of their fireplace and supported healthy life. It was made possible by road transport. Transport helps the regular supply of medicine in health post too and food supply from the market.

In this way, the ungraveled road has supported the people's access to hospital. But it is not fully reliable due to bad road condition and the problem of bridge in Melamchi River. They have got the other healing options after the transport facilities. It has made it easy to go to city hospitals, which brought change in the locals' medical practices.

Communication. All the households use electricity in Melamchi Ghyang. It was supplied since 1990 from the small-scale hydroelectricity project of Phadung Khola, established in 1986. It supported the communication system. Now this hydroelectricity project has stopped and the main grid of electricity is connected. Most of the households have televisions along with Dish Home, and it has contributed to choosing among medical options due to the information about treatment systems. Thus, they have become familiar with the modern practices.

There are three FM radio stations: Melamchi FM, Sindhu FM and Sunkoshi FM. Their broadcasts are easily heard in Hyolmo region. They also broadcast health awareness programs. Namobuddha FM, Kabhrepalanchok and some FM broadcasts with Kathmandu station are also heard.

Communications explicitly increase people's determination to modify habits detrimental to their health (Bandura 1990). Means of communication has the capability to alter health habits and instruct them on how to do it. These means of communication have direct and indirect impacts in health sector. One of the respondents studying in higher secondary levels relates on the impact of communication in healing choice,

> TV is more popular than Radio in Melamchi Ghyang as Sindhupalchok is declared the load-shedding-free zone. People are not much busy and they watch different TV programs and they have become clever. Local FM stations broadcast awareness-related programs on health. Now, people do not fully depend on traditional healers. The traditional healers are consulted only as an initial resort for healing.

This statement was supported by many informants during their interview. Now there is telephone service. Telephone was not commonly used in the past. Indradev

Yadav, one of the oldest teachers of the local high school, who is residing in Melamchi Ghyang for more than two decades, shares about the problem of communication in the past and its changes now,

> There was no telephone service in Melamchi Ghyang in the past. Later, telephone service was started in Tarke Ghyang, where there was only one telephone line. I used to go there spending a whole day for a call. Now, communication has been easy due to mobile phone service. Everybody has cell phone and can contact their relatives during health problem. It has also made easy to call helicopter in the village for serious cases and supported to contact Melamchi Hospital about the presence of doctor. People directly talk with *Aamchi* and take advice. Some people call *Bhombo* from other village. Telephone and cell phone have made the healing service faster and easier.

Other teachers also support his argument and claim that they look for the solution to health problem searching through Internet, but it is too slow and not much reliable.

Hyolmos were found having good communication service and they have almost regular talk with their family members who live in Kathmandu or abroad. The referral cause, knowledge about health service, and information about the availability of healers have changed the medical choice toward faster service along with the choice of better alternatives.

Foreign employment. Human mobilization for employment across national borders, is increasing. Economists and policy makers are interested in the vast amount of money flowing from migrants' host to home countries, most often from high-income countries to the middle/low-income countries. Remittance reached US$ 167 billion in 2005 (IOM 2006), with more than half being sent to the middle/low income countries (Gammeltoft 2002). These international transfers from migrants to their home communities have been recognized as playing a significant role in the health and well-being of recipients by financing the purchase of food, clothing and housing; educational expenses; land and businesses investments (Rozelle, Taylor and DeBrauw 1999; Taylor and Wyatt 1996) and health care services (Frank et al. 2009; Lindstrom, Munoz-Franco 2006). Foreign employment has played significant role in the health seeking behavior of Hyolmos.

The main occupation of Hyolmos three decades before was animal husbandry. Due to their hard transhumant life, they gradually shifted to occupation other than transhumant herding. As a result, their economic status elevated. Now their major source of income is foreign employment. Hyolmos have gone to mainly India for work, and some of them are working in US, UK, Israel, Korea, Hong Kong, Canada, Finland, Dubai, Kuwait, etc. Among the foreign employed locals, the member of about 46 percent households are in India, and more than 8 percent are in US and 2 to 5 percent are scattered in other states (see Annex Table 3).

Bishop (1998) applies the term 'circular migration' to this process of migration of Hyolmos, mainly the migration for short period to work in India and to return. Circular migration to India has given both negative and positive impacts on local people. As she states, besides earning, numerous reports of alcohol-related problems as well as death, sexually transmitted diseases including AIDS, etc., have endangered the health of wage labor migrants.

Foreign employment has enhanced their economic level on the one hand, which has influenced the better choice of healers in advanced hospitals, and on the other hand, school-aged children cannot go to school due to their parents' seasonal employment in India, which is one of the factors that hinders their education. Only the children were found at some home in my visit of June /July whose parents had gone to India to work.

Generally, persons who go abroad have adopted allopathic practices due to economic strength. A 53-year-old local male informant, Kami Sherpa, has a son in Korea, the next son is in UK and daughter-in-law is in Hong Kong. He used to go to *Dhami/Jhankris* to heal in the past when all his family members were with him in village. Now his medical choice has been changed. He clarifies in this regard,

> I used to go to *Bhombo* when I was ill in the past, but my sons and daughter-in-law enforce me to go to the hospital of Kathmandu (he took the name of some hospitals like Om hospital, Stupa hospital, B & B hospital) and not to depend on *Bhombo*. They send me enough money that I need for my treatment, and now I go to the hospital of Kathmandu when I feel sick.

Another 70-year-old male informant, Damai Lama, also has his son in the US, daughter-in-law in India and granddaughter in Canada. He shared that they do not support

economically in normal situation but have strong support for medical care. He informs smilingly,

> My family members generally do not support in normal situation but they have told me not to compromise in health care issue, and they send the necessary amount when I feel ill now. I go to advanced hospital of Kathmandu. Recently I had overall check of my health after the suggestion of my son living in the US.

He looked satisfied with his family members' response. It also clarifies by his response that health is regarded as an important aspect by those who are abroad. It shows both health consciousness and economic efficiency.

Foreign employment has made the people aware, which has supported to use the allopathic medical practice. As a result, the belief system in traditional healers and the ethnomedical practices are decreasing.

Before the establishment of health post in Helambu, the people who worked in India seasonally used to bring normal allopathic medicine in the village. Generally they go to India after the celebration of Lhosar (in February) and come back in September, October. They became familiar with allopathic medicine in India and also brought some medicines when they returned to their home. Many villagers claim that the beginning of western medicine is by Indian returnee villagers. The villagers have been working in different places of India such as Laddakh, Himanchal, Arunanchal, and Assam even today. When I was in Melamchi Ghyang in January and February, almost all the households were full of family members who came to celebrate Sonam Lhosar, and when I went again in June or July, there were very few people in most of the households, and some of the same houses were empty.

It is also found due to foreign employment in India for six to nine months in a year animal rearing has stopped, as it cannot be continued if they do not stay at home throughout the year. There were only children in some houses who went to school. Herbal collection became impossible when they left transhumant herding and the herbal practice for medication has almost ended with the work abroad.

Tourism. Helambu lies in the Langtang trekking route. It is one of the oldest trekking routes in Nepal, developed in 1970s. Now, there are eight guesthouses in

running condition. Before the opening of this trekking route, a few tourists came, and they were accommodated in personal houses or even stayed in an open area using tents.

September, October and November are the tourist seasons, when a remarkable number of tourists visit, and the next season is March, April and May. A few tourists visit even in the off season. Both the negative and positive impacts of tourism are faced by the locals.

Despite the economic promotion of the limited locals, tourism has brought negative culture. The villagers are worried in this matter. This point is supported by the following statement of a villager, who claims,

> Tourism has brought insecurity in the village. Before the tourist went in the village, they did not lock their door gates. It has raised the expense so that we have to buy goods at high cost. The traditional norms and values are also declining due to tourism. There is discrimination in hospitality for native and foreign guests as foreign guests are always in the first priority.

Tourism has made the villagers prosperous economically on the one hand, and it has introduced western medicine on the other hand. Tourists have contributed to change the villagers' medical behavior towards allopathic practice. Some tourists bring normal medicine and give to the villagers if needed.

Melamchi Ghyang is no more isolated due to the expansion of transport and communication. Many Nepalis also go there for trekking, pilgrims, tour and business. They also have contributed to change the locals' medical practice. Sometimes villagers ask the tourists to bring the needed medicine from medical shops of the bazaar area of Chanaute and Melamchi (bazaars at lower area from Helambu).

Trade route. Helambu is located in the middle of a triangle of the trade route that links Kathmandu, Nyenam and Kyirong. In Kathmandu valley the two main settlements, namely Swoyambhu and Bouddha, can respectively be seen as the end points of the Kyirong and Nyenam trade route to Kathmandu. Until two generations ago, people travelled from Helambu to the east via Thangpal, Gunsa and Golchhe, a journey of two to three days for the salt/grain trade. In the past, Hyolmos travelled through this route with rice, cloth, peppers and thread, and returned not only with salt but with wool, blanket and sheep for sale to Hindu people for the festival of Dashain (Clarke 1980 c). A local teacher

of the high school, claimed, "The native *Rongwa* used to come in Melamchi Ghyang from a long time ago as it is a route of Kyirong to take salt. Timure, the border of Rasuwa and Tibet, can be reached through Melamchi Ghyang via Semchhelang pass." Nowadays these routes are not in use. It is normal to travel to the east using the motorable road.

Melamchi Ghyang was the traditional trade route to go to Timure border of Rasuwa Gadi via Semchhelang pass, said Purna Gautam, the head teacher of the local high school. These routes connected Hyolmos with other communities in the past, which has influenced every aspect of life including medical practices.

Economic prosperity. In Melamchi, herders faced economic constraints from the factors of geography and history. Melamchi herders were isolated from services and information. They had no access to veterinary medicine and clinic (Bishop 1998). Due to their hard herding life, they gradually shifted to the occupations other than transhumant herding. As a result, their economic status elevated.

Economic status seems to be the major factor for medical choice among the Hyolmo people. The major income source was transhumant herding till 1970s. Then tourism began in the area and some local people started tourism-related business such as hotels and lodges, and they have better income now. The practice of transhumant herding is limited only in six households now, and the locals have started to go abroad in search of better opportunities. The person who goes to India earns 50 to 60 thousand rupees annually on average, and the couple earns almost the double, which the local villagers cannot imagine staying in the village. Those who go to countries other than India were found in further better economic status.

Land ownership in Melamchi Ghyang has recently changed from *Guthi* to *Raikar* (private). About 94 percent people have *Raikar* land, which was under the *Guthi* of Chiniya Lama till 2000. The transformation in ownership of land from *Guthi* to *Raikar* has increased the yields a bit, local people claim. The local vegetables are sold in hostels of the school or in market nearby. Youths have entered the city area, mainly Kathmandu, after their high school education, in search of better opportunities. Some local youths are employed in local area. Some of them have started to get involved in labor work such as building construction. In this way, the people have increased their economic level. About 50 percent households have home in Boudha area, Kathmandu, and house rent collection

is the next source of their income. In this way, the people of Malamchi Ghyang have changed their economic status, which has increased the choice of medical alternatives along with their material culture.

Putali Sherpa, a member of Mothers' Group, who stayed India for long and returned, mentions that economic growth has changed the healing options. She argues,

> The local production is not enough for livelihood for the whole year in almost all households. Therefore, many of the villagers have left their traditional animal rearing and agriculture and have gone to India to work. They work there in jobs somehow similar to the jobs that they do in village, but earn far better. The people living in village also have started to search some options for income. Many villagers are rich now. They can afford doctor's fee and medical cost. Some 3-4 cases are there annually in which patients are taken directly to Kathmandu through helicopter charter by paying about 75 thousand rupees in an event. Now various medical options are closer to the villagers due to their economic strength. In the past, they depended only on *Bhombo* or herbal practice. Now the situation has changed due to better earning.

The other members of Mothers Group also had similar views during focus group discussion**.** Along with the economic growth of local Hyolmos, their healing practice and medical choices was found changed. Many informants had clarified these changes. Some of the villagers have treated in some expensive hospitals of Kathmandu. Due to the affordability of villagers to treat in city hospitals, economic growth has contributed to increase the tendency towards allopathic medical practice.

The economic growth has not only changed the choice of medical practice but also has accelerated the healing procedure. Villagers share that *Bhombos* come to the patients' house at a single call if rich people call them. They hope to get better return from the rich houses. *Aamchi* is also invited in the village. The villagers conclude that fast treatment is possible due to economic prosperity.

Establishment of health post and hospital. After the establishment of health post in 2011 in Melamchi Ghyang by the support of CAN, the locals' first choice has become health post in health problem. About 47 percent household heads share that they go to health post first for the basic health facilities for themselves and for their family

members (see Table 15). Common health problems like common cold, diarrhea, cough, BP, vaccination, pregnancy test, delivery, fever, etc., are treated in health post. There is a staff nurse to facilitate the locals. Further treatment of patient has been made possible from the occasional visit of doctors. The locals who fully depended on traditional healers in the past have started to go to health post now. The reason to choose health post is education and awareness on the one hand and its reliable facilities and cheap cost on the other hand. People get all the facilities of health post throughout the year when they become member of health post by paying Rs. 100 per person annually. Medicines are also available free of cost.

Rinki Sherpa, the staff nurse of the local health post (Ninja Rinjen Community Health Service centre), claims, "All people come to take service in Health Post except for *Bhombo* and Lama themselves. Even the family members of Bhombo and Lama are facilitated by HP. The local people are also satisfied with the facilities of HP. They expect a modern hospital in local area".

Melamchi hospital is the nearest hospital from Helambu, which is about 40 km far. It has also facilitated the Hyolmos. The health post refers patients to the hospital in complicated cases. Due to the availability of health post and hospital, the people who used to go to traditional healers have now started to get the facilities in health post and hospital.

Devraj Dahal, teacher of Golma Devi High school, Timbu argues,

> The new generation of educated villagers prioritize going to health post. Now the old generations also have started going to health post due to the influence of new generation. Allopathic medicine is reliable and more effective. It is cheaper a ticket at 2 rupees is enough for checkup in government health post and Rs. 100 per person per year is needed for CAN supported health post. The government health post brings medicine from district health office and CAN supports to provide medicine under its health post. Both types of hospitals are not expensive. As they are accessible in the local area, people prefer health post the most.

The villagers prefer health post due to its location, as it is situated in the centre of village. People go there first in every minor and major case. Even the people who have indigenous healing knowledge began to go to health post. The villagers also have a sort

of worry after the establishment of health post that ethnomedical practices and knowledge are decreasing/disappearing due to the decreasing number of its users. An aged informant Karchung Ghale presents his worry about the declining state of ethnomedical knowledge,

> The idea of home-made remedies is going to be lost in Hyolmo region as everyone likes to go to health post for every health problem. If health post does not provide treatment in the future, where do we go? *Bhombos* are also decreasing in number. Herbal practice is also declining. The practice of self-medication is also going down.

His face seemed to express worry about the dependency on health post and on the loss of their indigenous knowledge. Some other social leaders of old generation also expressed similar views regarding the negative aspect of health post.

Link with Kathmandu. Though Melamchi Ghyang is a rural area, many villagers have started to follow modern medical practices due to the link with Kathmandu. The villagers have the trend of using allopathic medicine now: 50 percent of the locals have home and 27.08 percent of them have land in Kathmandu (see Annex Table 11). Rests of the villagers also visit Kathmandu frequently as they have relatives, or for business or their children as the students have come to Kathmandu for higher studies.

The people of Melamchi Ghyang have a strong historical link with Kathmandu. Both the Bouddha Ghyang Guthi, Kathmandu and Melamchi Ghyang Guthi Melamchi Ghyang were under the control of Chiniya Lama's generation who live in Bouddha and visited frequently to Melamchi Ghyang

The villagers now earn from different sources and invested in the land in Kathmandu. This resulted in increase in the number of allopathic users and they got opportunity to choose the other alternative medical practices which are not found in Melamchi Ghyang, such as homeopathy, Ayurveda, acupuncture, yoga etc. These alternatives are also familiar now among the Hyolmos reside in Kathmandu. Prakash Sherpa Hyolmo resides in Bouddha, Kathmandu. He shared his healing experiences,

> Hyolmos who reside in city area use various medical alternatives. I also had used Ayurvedic medicine from Naradevi, Kathmandu, for piles. I am completely well now. I had gone to *Bhombos*, health post and hospital for its treatment. I also used

> local herbs but could not become well. Now I have various medical options as I live in Kathmandu. There was no patient of BP, sugar, uric acid, cancer, etc., in the past, now there are many patients of these health problems; and it is impossible to treat such problems in village area. They are treated in the hospitals of Kathmandu. It is possible as many villagers have link with Kathmandu.

The link with Kathmandu has Hyolmos progress economically, made them familiar with modern medical practices, have more medical options, and are aware on the choice of various medical practices.

Inter-marriage practice. Inter-caste/ethnic marriage was strictly prohibited among Hyolmos in Melamchi Ghyang till three decades back. Some old informants claimed that they were not allowed to marry even the Hyolmos of Nakote (nearby village of the same ward of Helambu). They used to get married with Hyolmos of a different clan. There are five clans under Hyolmos in Melamchi Ghyang: *Ghale, Syangba, Jhhyaba, Yoba* and *Lama*. But now inter-marriage is common among them: 65.7 percent HH heads prioritize love marriage (see Annex Table 7) because they claim that the partner can understand each other in love marriage; 82.29 HH heads accepted that inter-marriage is common in their community (Also see Annex Table 8).

Inter-marriage practice began since 1980s when Hyolmo youths started to work abroad and went to Kathmandu for business and higher studies. This practice accelerated with the development of transportation and communication. But Hyolmos still do not accept the marriage with Dalit castes.

Marriage is one of the major means of diffusion of culture. Medical practice is also a cultural part; we can observe some changes in medical choice due to inter-marriage. Bride brings new ideas of her culture related to health problem and tends to apply them in new home so that some changes in traditional herbal and home remedies are found. The next is the referral cause which is made by the relatives established after inter-marriage; they get alternative opportunities in medical practice. Bilateral cross cousin marriage *(mama cheli phupu chela, and mama chela phupu cheli)* is also practiced. Clark (1980 b) gave the kinship terminology as 'two–line symmetrical kin' for such relationship. Informants shared that *mama phupu* relation is common whereas

daughter of mother's sister is not married. But it is also decreasing due to inter-marriage practice (p. 80).

Like the Tamangs, Yolmo people prefer cross-cousin marriage, a form of marriage that has the potential to produce "intensive alliances among a small set of patri-clans residing in Neighboring villages" (Holmberg 1989, pp. 30-31)

A 48 years female respondent argues:

> Love marriage is increasing due to abroad work, study and link with city. Inter-marriage is also increasing along with love marriage. Love marriage is accepted only if it is within Hyolmos in the case of those who reside in village; but those Hyolmos who live out of the village with different purpose practice inter-marriage and there is no option other than to accept them. Then, either girl or boy who practice inter-marriage have link with other culture and they exchange the medical knowledge and practice.

Medical choice is also changing due to the economic support made by their relatives. In this way, expansion of healing ideas and the support from relatives have brought a little change in medical choices.

Some events of daughter-in-laws going to her maternal house for treatment have also been observed in the event of sickness. Such events occur if there is *Jhankri* in her birth village is more powerful than the local *Jhankris.*

Langtang National Park and community forest users group. Langtang National Park was established in 1976. It covers an area of 171,000 square kilometers in three districts: Rasuwa, Nuwakot and Sindhupalchok. Melamchi Ghyang was incorporated in the park only in 1986. Helambu is a VDC adjoining Lantang National Park, and Melamchi Ghyang village is very near the park, less than 1 km. The villagers are not allowed to enter the jungle area to collect forest products as it is the protected area. For the systematic use of forest products, a community forest users group (*Dhupu Samudayik Ban Samittee*) is formed. The national park and community forest users group have controlled the use of forest products. A limited amount of firewood and fodders can be collected and used systematically, but herbal products are strictly prohibited to collect. Focusing its impacts on socioeconomic life, one of the female consumers of jungle resource shared in a sad mood,

> To collect firewood is very expensive. The wood collector should be fed four times a day with payment of Rs. 400 daily. It is because of the lack of dead trees found nearby, which can be used only for firewood, and there is lack of manpower. A bundle of firewood costs Rs. 120 or more on average. It is as expensive as LP gas. Therefore, locals have started to use LP gas when the village was connected by road transport.

Mothers Group of Melamchi Ghyang also protects the jungle area. Pasang Lama, chairperson of the community forest users group, shares,

> The forest products are used systematically. It is made open only for two months of the year. Firewood is collected at that time. The straight trees and medicinal plants are not allowed to cut. Varieties of the herbal plants are found in jungle like *kutki, panch aunle, nirmasi jatamasi, chiraito* etc. *Yarsagumba* is also found in high altitude of above 4,000 meters. These herbal products were used haphazardly in the past even if they were protected because of low population. Later, population increased in the village. People from other villages and strangers also began to collect the herbs, and we started to control. Now no one, including local villagers, is allowed to collect herbs. We have made strict rules to use forest products. If people are found collecting these herbal plants without permission, they are fined. In the initial stage, Rs. 5,000 is applied as penalty.

The same version was given by Putali Lama, the member of local Mothers Group. The collected amount from the fine is used in the welfare of village. District Forest Office will punish if the case is repeated, but this situation has not occuted so far.

There are 15 forest types and more than 1,000 species of flowering plants and ferns and medicinal herbs within the national park (Shrestha 1985). Due to the strict policy of national park and forest users group, mass production and business of the herbal products is not possible. The local herbalists are feeling difficult to get medicinal herbs.

There are no skillful herbalists by profession, but the traditional herbalists who use the herbs to treat the family and community are also feeling problem.

Case Study 8: Declining Condition of Herbal Practices

Tashi Hyolmo is now 78 years old. He was renowned herbalist in Melamchi Ghyang and cured innumerable cases of illnesses in the past. He left his profession about a decade ago. I asked his past events and he explained:

Aba budo vayo. Kaam garma saktaina. Now, I am old and cannot continue my profession. Young villagers are not interested in it and I could not transfer my knowledge of herbal practice to the new generation. I myself also felt problem to continue and I left it in the later days. The main cause was Langtang National Park. When it was established and occupied this area, almost all *'gothwala'* (transhumant herders) left herding practice at once due to a rumour expanded throughout the village that National Park does not allow to enter in jungle, graze their animals and collect jungle products including herbs. The herders used to travel to the jungle area, reached at the top of hill in summer, collect useful herbs and bring to village. I also used to collect herbs with transformation of 'goth' indifferent grassland area. I used to collect plenty of herbs and serve the ill people of the village. When this practice declined, I felt problem to continue herbal practice.

Now there are very few *'gothwala'* and they also do not have knowledge about herbs. They only know few of the herbs such as *'kutki', 'panch aunle*', '*ban satuwa*', '*ban karela', 'ban lasun', 'pakhan ved', 'thulo okhati',* etc. There are many other useful herbs found in jungle.

When I was collecting a few items of herbs from jungle nearby village at lower altitude, it was also restricted by Dhupu Community Forest Users Group. The group made strict rule with fine system for herbs and firewood collectors. Then, herbal practice almost came to end.

I had neither extracted herbal medicine in large amount nor sold. But National Park and consumers group applied strict rules than needed. Now my skill is going to die. I had saved the life of many persons. Now, neither I can continue nor there is any person who protects this knowledge. Health post is established; probably it will save our villagers.

Now, health post provides necessary medicine in low cost and has fulfilled the need of villagers. A very few villagers depend only on herbal practice of medication for particular health problem.

While getting such hopeless information about herbal medical practice, the *Aamchi* of next village (Nakote) who uses herbal plants as medicine shared views different from the herbalist, "I collect the herbal plants when I need. This is a social work. I have not used these herbs for my personal welfare. Everybody becomes ill and need medicine. No one has stopped me so far and I hope no one will do so".

Aamchi also uses herbal plants for treatment, but the area where he lives is not incorporated under the National Park when the people refused to be included in 1986 (Bishop 1998). And he has also got villagers' support. Now, use of herbal medicine is limited because of the strict rules on the use of forest products. Villagers' claim is different – that some limited herbs can be collected for community use but herbalists hold themselves back due to their less effective medicine. The villagers want more effective medicine for prompt recovery, which is possible only by using allopathic medicine.

Other associated causes. Hyolmos claim that there is no change in religion, rites and rituals. They believe that the god/goddess will be angry if changed. Some villagers are not in a mood to change them, thinking that their traditional identity ends if it is changed. Lamas also claim that there is no change and the change is not better as they feel proud on their rituals. But some changes were observed because of the change in their material culture. Due to their economic growth, they have been using modern materials even in religion, rites and rituals. There seem changes in food and dressing pattern such as the use of electric heater and rice cooker instead of firewood, use of Horlicks instead of roasted flour, metal lamp for worshipping instead of clay lamp, pot, etc. Bishop (1998) states that Melamchi diet has changed substantially due to the cash earned from wage labor and circular migration such as using milk tea, coffee, and the modern drinks like Fanta, soda or beer. Uses of these beverage and foodstuff have contributed to change the healing and medical choices indirectly.

Melamchi Ghyang is the place where there is still very less influence of politics. Hyolmos have much less interest in politics. Some influences are observed after the Peoples' Movement II (2062/63). The previously single party follower Hyolmos are now

divided into major political parties. It has made possible to link with other communities. This process has also influenced their medical choices to some degree.

Summary

Hyolmos' medical choices are changing for around three to four decades. Their choices, priority, procedure and even belief system are found changed. Several factors have been playing significant role for such change. Education and awareness is the prime factor to bring about such changes. School and adult literacy classes have made the locals aware in their health condition and healing process. Informants with formal education have given high preference to allopathic practice. Similarly, Hyolmos' economic prosperity made it possible to choose the best medical alternatives. They are economically better and have access to hospitals and treatment procedures. In recent decades, Hyolmos have gone abroad to work and this has influenced local peoples' medical choices. Now Melamchi Ghyang is facilitated with transport and communication, which brought remarkable changes in medication practice. The locals who depended fully on traditional healers in the past have started to go to Melamchi Hospital or Kathmandu now for better treatment. After the establishment of health post, locals' health behavior changed drastically as they prefer to use allopathic medicine as the first choice. The health post is giving health care at a low cost. The number of *Dhami/Jhankris* is decreasing and herbal practices are also declining along with the establishment of health post. Inter-marriage and the link with Kathmandu helped to bring Hyolmos in touch with the outer world. These practices have contributed to cultural exchange.

Establishment of national park and community forest users' group resulted in the decline of herbalist's profession. Tourism and political factors are the minor causes which brought change in Hyolmos' health-seeking behavior. All these factors mainly changed the traditional medical choices into allopathic practice. Now allopathic medical practice is an established practice that many Hyolmos follow.

CHAPTER VIII:
LINKING EMPIRICAL FINDINGS TO THEORIES AND LITERATURE

This chapter describes the major findings drawn from the analysis, interpretation and discussion resulted from the collected data/information and linked with theories and literature. The major findings are divided into different groups according to the objectives of the study. Then the discussion is made after listing out all the findings. The findings of this research are discussed with the literature, theory, and my personal reflection about the study. Furthermore, debates and issues related to the results are also discussed and highlighted.

Anthropology talks about health in a broader perspective and deals with it as a complete code held by any population including perception about well-being of population, notions on curative and preventive aspects of treatment, treatment patterns according to the severity of diseases and set of practices and associated faiths. Mechanic (1969) states, Anthropologists generally see 'health' as a broad construct, consisting of physical, psychological, and social well-being, including role functionality.

In this study, I apply Kleinman's (1978, 1980) explanatory model, which incorporates the individual cultural response to illness and treatment. This model refers to the patient's and family's conceptions of the nature of particular illness episode, its causes and effect, desired treatment and apprehension about the outcomes. Kleinman (1978) proposes a theory using the Explanatory Model (EM) to describe illnesses in different sectors of the health system. For each illness, according to EM approach, there is a set of beliefs about its etiology, onset of symptoms, pathophysiology, development, severity, and treatment as well as about appropriate roles for those afflicted. The EM approach provides a way to make cross-cultural comparisons of health-seeking behavior (p. 86).

Anthropologists such as Naeemah, Rachel and Zodumo (2002) have followed similar health-seeking practices within three overlapping sectors – the biomedical sector (modern western medicine), the folk sector (traditional healers and faith healers) and the popular sector (self-medication and lay treatment). Although practitioners of the formal folk sector are often regarded as the main repositories of indigenous knowledge, lay 'practitioners' of the popular sector also deserve attention. It is here that ill-health is first

recognized, health care activities initiated and sets of beliefs about health maintenance are held and acted upon.

Linking the Major Findings with Conceptual Framework

To explore the existing medical practices, I had assumed that *Dhami/Jhankris*, *Aamchi*, self-medication, Ayurvedic practice, homeopathy, Unani, allopathy and religious healing practices are incorporated in the conceptual framework. There is no prevalence of homeopathy and Unani healing practice in Melamchi Ghyang. Ayurvedic tradition also does not exist locally, but people are familiar with this practice. Hyolmos residing mainly in city area have practiced it. The major healing and medical practices are *Dhami/Jhankris*, self-medication, allopathy, religious healing and *Aamchi*. The empirical findings of these practices are discussed below.

People of every community like to live healthy life; so they use different preventive and curative measures. Medical pluralism is a universal phenomenon. Medical pluralism is a theoretical model that has represented most of the world's medical systems (Burghart 1996; Durkin-Longley & Maureen 1984; Good 1994; Hare 1993; Kleinman1980, Pigg 1995, 1996; Rashid 2008; Stoner 1986; Subedi & Subedi 1992; Weller, Ruebush & Klein 1997). As a prominent theory, it suggests that most cultures are host to several medical systems operating and existing in tandem. It is a very common practice in all parts of Nepal. Within this report, I have explored the plural medical practices existing in Hyolmo community.

Hyolmos, one of the ethnic minority groups, are residing in Helambu area, the high hill of Sindhupalchok. They use various medical/healing practices for the treatment of illnesses. There is strong influence of climate on the health of people. Many studies support the link between temperature and mortality (Ellis 1972; Ellis, Nelson, & Pincus 1975; Oechsli & Buechley 1970). The impact of weather on human well-being goes beyond mortality; even birth rates and sperm counts appear to be affected by meteorological phenomena (Calot & Blayo 1982). However, there are many other impacts of weather on the general health of the population, such as morbidity, short-term changes in mood, emotional well-being, and change from normal behavior.

All people are not influenced equally. Certain sectors of the population appear more affected than others. Most victims fall in one or more of the following categories:

the elderly, newborns, the unconscious, alcoholics, and people on medications (Hudson & Conn 1974). Being the people who live in cold climatic area with occasional snow fall, Hyolmos are healthy in general. Environment plays an important role in illness issues. The other study done by Stokols (1992) also indicated the impact of environment in health and sickness. The environment can be viewed as a guiding factor of health behavior.

General health problems of the people of Melamchi Ghyang are the problems caused by cold, such as common cold, cough, headache, cold diarrhea, uric acid for aged people, and pneumonia for children. These diseases are mainly caused by cold climate as the place is situated in remarkable altitude (2,600 m).

Now some people suffer from new but more harmful diseases such as gastritis, high blood pressure, diabetic mellitus, TB, cancer, etc. The local people name these diseases as *sahariya rog* (urban diseases). According to Jones, Timothy, Mary, Mishra, & Jayachandran (2009), rural residents have higher rates of age-adjusted mortality, disability, and chronic disease than those living in urban areas, and they have lower access to health care in terms of affordability, proximity, and quality. Local people know that BP is caused by the excessive use of salty tea and TB is by excessive cigarette. They claim that these problems appeared in the village due to the urban impact.

It is commonly held that Western medicine is appropriate for adults but is a constraint for children (Parker 1988). In Hyolmo community, children are not given western medicine in the general cases but immunization is common to them now.

Sex is the next determining factor for the medical choice. Various researches have demonstrated that self-medication is more prevalent among the females victimized by either loneliness or psychological problems, or poverty, and among students as well (Shankar, Partha, & Shenoy 2002). Self-medications, mainly the home remedies, are found among Hyolmo females.

Findings on the Existing Medical/Healing Practices

Hyolmos practice both traditional and modern medical practices now. Traditional medicine in Nepal has strong cultural and religious background. It exists in different ways such as in ethnic or tribal groups, ritual or ceremonial practices, spiritual practices, diet or self-healing practices. Indigenous and local communities have been using

traditional and indigenous knowledge for centuries under local laws, customs and traditions.

The preventive side basically covers the principles of adopting strategies that prohibit the outbreak of diseases and further help in preventing the spread of diseases and germs. Until the person feels a serious problem, he does not follow preventive measures. Ewart (1991) states, prevention entails creating self-protective habits in the form of highly routinized and 'automatic' action sequences that lower personal risk. Hyolmos practice less preventive and more curative measures of health behavior.

Rush (1996, p. 138) says, "If a society or culture does not develop procedures for healing and curing, it does not exist". Indeed, Hyolmos' plural medical system developed from its remote history, as I explained in Chapter Four. On the basis of Kleinmans' (1978, 1980) model, Hyolmos' different medical practices are categorized into three broad types: the popular sector, folk/traditional sector and professional sector. The popular sector consists of health care conducted by ill persons themselves, their families, relatives, social network and communities. It includes a wide variety of therapies, such as special diets, herbs, exercise, rest, and baths or the counter drugs. Among the popular practices food pattern is the main one. People use general food item but their timing of food has played the remarkable role for their healthy life. Food habits of the villagers have protected their health. The local organic, fresh food items and vegetables, milk production and their timely use have strongly supported Hyolmos to be healthy. Now, due to the access of transport and urban impact, people have started to use junk and packed food items which weaken the peoples' health.

The diseases associated with poor sanitation are particularly co-related with poverty. At any given time, about half of the urban population of Africa, Asia, and Latin America has a disease associated with poor sanitation, hygiene, and water (WHO 1999). Hyolmos have better cleanliness and sanitation. The houses and surroundings of Melamchi Ghyang are clean. All the households except for two households have toilets. Majority (78.12 percent) of households have traditional toilet (pit latrine, in which dried leaves are used), 21.78 percent households have concrete toilet, and 6.25 percent households have concrete toilet under construction. The households which do not have

toilet share neighbors' toilet. Helambu was declared Open Defecation Free (ODF) on 10th Ashar 2071 B.S.

There was problem of drinking water in the past due to the source being far and lack of its proper management. Now, there is not much problem due to the reservoir tank. Water is not purified, but it is drinkable because the source of cold water is the mountain.

Physical labor is their exercise. The villagers argue that their regular movement in the hill area automatically maintains their exercise. They are also involved in meditation as Melamchi Ghyang is the traditional meditation centre. Meditation is common in the village, but it is practiced only for religious achievement. However, it provides mental peace. Both native (mainly Lama) and foreigners come to the Chandra Surya cave above the village for meditation, where it is believed that Guru Rimpoche had meditated in the 8th century.

Self-medication trends in different regions of the world are high (WHO 1998, Bradley & Blenkinsopp 1996). And it is alarming despite the efforts made to curb this problem (Hsiao, Jen-Ai Lee, & Hsiang-Yin 2006). In economically deprived countries, most episodes of illness are treated by self-medication (G/Mariam & Worku 2003). For instances in India, it is 31% (Deshpande and Tiwari 1997), and previous studies have concluded that the rates of self-medication were up to 51% in Pakistan alone back in 1995 (Haider and Thaver 1995). It increases day by day both in the developing (Geissler, Nokes, Prince, Odhiambo, Aagaard-Hansen, & Ouma 2000. Sawair, Baqain, Abu Karaky, & Abu 2009) and developed countries (Richman, Garra, Eskin, Nashed, & Cody 2001). Self-medication is practiced not only in the developing countries, but also in developed countries despite knowing the negative impact of medicines. In Spain and Turkey, the ratio of self-medication was 12.7 and 45% (Figueiras, Caamano, & Gestal-Otero 2000). In Hong Kong, it was 94% (Chang & Trivedi 2003). In most illness episodes, self-medication is the first option, which makes a common practice worldwide.

In Nepal, prevalence of self-medication is 59% (Shanker et al. 2002). One does not need a prescription to get medicine from the pharmacy. This is the same in many other countries (Miles 1998; Vander, Susan, & Anita 1996). The reasons to use are: it is burden free, cheaper, and traditionally accepted. Among the various curative medical practices of Hyolmo community, self-medication is the most used one (about 53 percent)

for primary treatment. Every persons use it, irrespective of age, sex, and prosperity. G/Mariam and Worku (2003) state that self-medication provides a lower cost-alternative for people who cannot afford the cost of clinical services.

Hyolmos have developed their distinct ethnomedical practices for recovery of illnesses. Traditionally home remedies are used as medicine such as hot water compression for swelling, drinking hot water with turmeric for common cold, *Bojho* for cough, hot alcohol for body pain etc. Now, people medicate on their own by taking medicine from medical shop or from health post. In Melamchi Ghyang, people use both the allopathic and herbal medicines as self-medication. It is one of the features of medical practice in marginalized society. In developing countries, both modern drugs and traditional medicines are commonly used for self-medication (Bond & Bradley 1996; Abulal & Worku 2001; WHO/FIP 2006; Mohan, Pandey, & Verma 2010. Abay & Amelo 2010; Bajait, Jaiswal Jaiswal, Pimpalkhute, & Sontakke 2011). Self-medication is a useful tool to treat minor ailments. Improper self-medication practice or medication abuse may lead to serious adverse drug reactions and possibly fatal consequences. Arzi, Ashtarinezhad, Sarahrodi, & Sawalha (2010) state that self-medication could delay accurate diagnosis and appropriate treatment, and could cause toxicity, side-effects, drug interaction and unnecessary expenditure.

Herbal practices are also followed widely in Hyolmo community. It is their tradition to use indigenous knowledge to be safe from illnesses. Herbs like *Jatamasi, nirmasi, panch aunle, yarsagumba, ban lasun, ban satuwa, ban karela, chiraito, bojho, kutki*, rhododendron etc., are found in and above Melamchi Ghyang. Among them, *kutki* is ever known and used for fever, gastritis, common cold and cough. Bhattacharjee and De (2005) state that traditional herbal medicine plays an important role side by side with modern medicine in the health care of the people, particularly in poorer sections, as western medicine is unavailable for many people due to economic and other reasons.

Now, the local herbal practice is also decreasing. Only a few locals know about herbs and their use. These medicinal herbs are collected by limited herders who shift their yak/cow shed to the high altitude in summer. This practice decreased when the health post started to provide allopathic medicine. Another cause of decrease is the Langtang National Park, which prohibited collecting herbs from the jungle of their area. Retnam

and Martin (2006) observed that ethnomedicinal plants are still used by all kinds of people to find cure for those diseases where modern synthetic medicines have failed. In Melamchi Ghyang, though it was a popular alternative practice, it is decreasing.

The next medical sector developed by Kleinman (1980) is folk/traditional practice, in which healing is performed by non-professional and non-bureaucratic specialists who have been trained informally or are experienced. This sector is considered an intermediate level between the popular sector and the professional health care sector.

As a traditional practice, *Kul puja (Kangso)* is performed by Lama to avoid bad days and to wish for peace, prosperity and healthy life of people. Hyolmos of Melamchi Ghyang increase their will power by doing their *kul puja* which they call *kangsu*. A clan *Jhhyowa* names this *puja Lhakyonge* and does it with the support of *Jhankris*. Other clans like *Ghale, Syagba, Yuba* and *Lama* do it with the help of Lama. The small *puja* (*fichyang)* is performed annually after Sonam Lhosar and the main *puja* is performed generally in every three years, which is costly economically. *Kul puja* helps to avoid bad time and brings peace, healthy life, and good omen. It is an important cultural practice to be mentally strong. Hyolmos who have migrated and gone to other places also perform it by inviting Lama in their residence.

In the highlands of Nepal, just as in many other regions of South Asia, multiple indigenous healing traditions and a variety of traditional curing specialists co-exist in a pluralistic cultural environment (Parker 1988). Among them, a popular indigenous healer is *Dhami/ Jhankris.* They are called *Bhombos* in the Hyolmo language or simply *Jhankris* in usual term. They are the traditional healers of Helambu. A study by Parker in a high hill area of Thak Khola, Mustang, in 1988 shows similar traditional healing practitioners such as Lama and *Bhombo*. The religious tradition of the region includes the elements of Tibetan Buddhism and Bonpo, local animism and (particularly in the southern Thak) Hinduism. Each of these traditions constitutes an internally consistent system of thought concerning the nature and composition of the humanly relevant universe. Nevertheless, these religious traditions are not mutually exclusive. There is considerable overlap in so far as each one has incorporated the elements of thought and practice from others.

All the *Jhankris* in the study area are males, which is the consequence of the predominant patriarchic values (which has barred women from learning and practicing

shamanism, because sexuality is always controlled by males). Their pioneer gurus (teachers) were in Kulu and Ghyangfedi, Nuwakot. But the present *Jhankris* had learnt it from the seniors of the village. They observe the body, watch grains, observe pulse or measure sacred rope to diagnose illness. There are *sano Jhankris* involved in *jharfuk* and *thulo Jhankris* who beat drum. The villagers, in the past, used to choose the *sano Jhankri* at first and later *thulo Jhankri* in the second stage in the case of complex problems. Now, the villagers seek service from the *Jhankris* whoever they meet at first, based on their availability.

They use incense, broom, ashes, floor of rice, ghee, lamp, cock, egg, and piece of colorful clothes, drum and other materials based on the cases of illness to heal. They heal any time except at noon, as they believe that the evil power becomes the most active at noon. Healing process takes two hours to the whole night depending on the complexity of cases. They recite mantras and used to slaughter animal, but nowadays animal sacrifice has completed stopped. The Mothers Groups of the village fine Rs. 5000 if animals are slaughtered.

Elderly people still prioritize *Dhami/Jhankri* (*Bhombo*) for their healing in Melamchi Ghyang because they are not expensive, are historically accepted, and are available when needed. Despite this, the number of *Jhankris* and their followers is decreasing. Young people do not like to follow this profession as it is not lucrative. Health post has been established in the village. However, in the particular cases like vomiting, fainting, heart pain at once, the villagers still prefer *Jhankris* for healing. *Jhankris* themselves are satisfied with their job as they get high degree of respect in the village due to their readiness to serve the villagers at any time. They claim that they have saved the lives of many people.

Aamchi practice has not much expanded, but an *Aamchi* of Hyolmo region, in the next village adjoining Melamchi Ghyang, is providing health service in Tibetan herbal system. He also uses herbs available in local area, but the epistemology of *Aamchi* is different from that of herbalist. *Aamchi* is a Tibetan word which means 'doctor who uses herbs'. He observes face and affected body part, asks about the symptoms and the history to diagnose the illness and provides medicinal herbs. He also inspects the patient’s urine and skin color. He claims that he can heal the patient suffering from diabetic mellitus,

jaundice, sinus, snake bite, food poison and many health problems. People have positive responses towards him but do not fully depend on him because there is a single *Aamchi* available in the area.

Hyolmos perform some traditional safeguard customs to protect themselves from evil spirit as preventive measure. One of them is *Bhakal* (promise made by person wishing to offer a religious dedication). Though it is a Hindu custom, Hyolmos, who are Buddhists, also commit *Bhakal* to Palchok Bhagawati, which lies in the adjoining VDC; or sometimes in Bhimsen, Dolakha. This culture is decreasing as Hyolmos started to claim themselves as Buddhists and wanted to abandon such a cultural practice of Hinduism.

Another traditional safeguard is to make gateway in the entrance spot of village which is called *Kakani*. It is the gate consists of the pictures of god/goddess; and it is believed that evil power cannot enter the village crossing the gate. Similarly, they use mascot for individual safeguard. Children are given mascot by *Jhankris,* whereas a sacred thread is given by Lama to adult Hyolmos as a means of safeguard. Mascot is used either in neck or in arm to protect the individual from illness.

They also consult expert Lamas to know their future and to avoid probable difficulties. Lamas control the cosmic forces through spiritual prayers. Hyolmos have a very strong belief in Lamaism. Lama, a Buddhist priest, performs rituals and puja, recites *Tripitak*, lights the lamp and worships in Gumbas against the supernatural causes of illness for the collective welfare of the community. Parker (1988) also states that Lamas are called upon to perform ceremonies of exorcism or appeasement if the affliction is deemed to be caused by a supernatural agent. They usually treat these afflictions by performing a combination of rites.

"There are a few comparative studies about prayer healing in Christianity, Judaism, Islam or other religious groups to show the similarities and differences of religious healing in various arenas" (Fosket & Jacobs 1997, p. 327). Such studies show that religious healing has its own influence on people's search for health and the regulation of the body. That is in Lamaism too.

People believe that Lama's performances bring good days ahead, wishes are fulfilled, and grief and pain are avoided. Despite these important roles of Lama, there is

not a single well educated (*padhe*) Lama in the village. Only *thare* Lamas (Lama by surname) are there who are not as powerful by knowledge as educated (*padhe*) Lamas.

The astrologer is able to suggest an appropriate source of supplementary treatment to the patient (Parker 1988). Lamas are the future predictors like astrologers in Hyolmo community. The Lamas watch grains, tell the fortune and predict the condition of patient. Lama education can be learned by both male and female, but only male can perform puja in Gumba, female becomes nun and has no cultural right to perform Lama's activities.

The third sector of medical practices developed by Kleinman (1980) is the professional sector; it involves the highly specialized training and knowledge-based educated providers of biomedicine, where there is formal position of practice. In the Hyolmo region, health post and hospital services are included within this practice. Younger generation with formal education prefer health post service which was established in recent years. People immunize their children and seek the service from the local health post.

Immunization is the preventive measure of illness. Hyolmos attend their children to the local health post. They began it two decades ago when the school was established. They used to go to Kharchung health post and in Timbu health post before the establishment of health post in the village. Circular migration to the Indian cities has also contributed to create awareness for immunization.

Allopathic medical practice is popular in Helambu. It is supplied by three health posts of different villages of Helambu. CAN-supported health post is running for some years. It has attracted the locals as it is a cheap with basic equipments and frequent visits of doctors. School teachers and students go and refer villagers to it. People feel more secure to follow allopathic practice because of doctors' visit and referral cause to well-facilitated hospitals. The increasing use of allopathic treatment has decreased shamanism. It has also contributed to decrease herbal practice.

Education is an important preventive measure of health maintenance which is not incorporated in the three sector modality developed by Kleinman. Education plays an important role in medical choices. Educated people have strong choice of allopathic medicine. Informants having formal education were found to be more conscious of their

health and hence were also found to be adopting modern allopathic medical treatment system. Similarly, they were also found to have given up superstitions. In the study area, new generations are educated due to local high school, and elderly people are getting adult education (literacy classes). Education has contributed to decrease the status of *Dhami/Jhankris* and their followers. It has also helped to decrease superstitious beliefs such as the tradition of animal sacrifice in healing illness. As Catania et al. (1990) state, education provides accurate and specific instructions on the health utility of (safe) behaviors and suggests ways to increase the enjoyment of low risk activities.

Findings on the Reasons of Plural Medical Attempts

In most parts of the world today, no single system is solely used; instead, multiple modalities exist and are used in parallel. Whether these systems are regional in context or institutionalized by the larger society, it does not seem to matter; people have multiple choices (Kleinman 1978). Many studies have supported the existence of medical pluralism in Nepal. Various authors have claimed that medical pluralism is well utilized throughout the various groups in Nepal (Acharya 1994; Blustain 1976; Dhungel 1994; Streefland 1995; Stone 1976). Like in other parts of Nepal, the people of Melamchi Ghyang also choose multiple options to get well soon. There are many reasons to use plural medical practices among the people in Melamchi Ghyang. The majority (61.45 percent) of household heads responded that attempting more than one medical practice is due to their availability. Andersen (1995) also states that enabling factors include the availability of health personnel and facilities, income, health insurance, regular source of care, travel and waiting times, and social relationships.

Medical choice depends on decision making process. The determinant model attempts to account for intra- and intercultural variation in health-seeking behaviors by examining the characteristics of illnesses, patients, caretakers, households, communities and health care services, as well as the individual's actions and willingness to seek care (Mechanic 1969, Colson 1971, Fabrega and Manning 1979).

The several reasons of plural medical practices are found in the study area. They are availability of services, cost of service, belief towards the system, intension to get well faster, previous experience about the service, and perception of peoples on the healers. Similar finding was drawn by Hussain and Khanum (2008); James et al., (2008);

and Almasdy and Sharrif, (2011) that previous experience was one of the major reasons for self-medication besides the availability of doctors and transport, ability to self manage, urgency to treat, assumption of better knowledge, lack of time and cost of treatment. Stone (1976) shows that in the several contexts of illness treatment, Nepali villagers easily combine western medicine with traditional practices.

People use those sources which are easily available: 51.04 percent informants prioritized on the basis of the cost of service provider to choose the service; 50 percent focused its cause to get well faster and 42.70 percent informants said that they consult the providers who are available due to belief in multiple providers. Only 3.12 percent people said they use more than one services due to the lack of belief in a single service provider. Hyolmos use more than one attempt to get well soon. Sometimes they use traditional and biomedicine simultaneously. The finding of Casey, Kathleen, & Jill (2001) also supports that those with low income, less education, lacking health insurance, and lacking knowledge about the potential benefits were less likely to utilize the modern health services.

Some of the informants also shared that they choose multiple medical services due to their referral cause as they go to different healers after being referred. This finding is also supported by Nichter (1978), that in the South Kanara district of India's Karnataka state a traditional referral network has emerged as a means whereby the multiple aspects of illness can be treated in the context of perceived multiple causations. Parker (1988) also found that in the case of co-existing systems of medical practice, the function of coordination may be served by referral system.

Findings on People's Perception on Different Medical Practices

Explanatory models are often used to explain how people view their illness in terms of how it happens, what causes it, how it affects them, and what will make them feel better (Kleinman 1978). Bandura (1990) claims that; the stronger the perceived self-efficacy, the more likely that people adopt the recommended practices. Thus people perceive different practices on the basis of their efficacy.

Hyolmos believe that health is the good condition of active life. They categorize illnesses into major (*thulo*) and minor (*sano*). The illnesses which cannot be cured locally are called major illness. These include TB, leprosy, bone fracture, blood pressure, AIDS,

paralysis and surgery. And minor illnesses include those which can be cured by local healers – such as cold, cough, fever, diarrhea, headache, etc. Now some big illnesses such as T.B. have changed into small due to the regular supply of medicine (Beine 2001). In this way, the category of illness is defined in terms of people's perception on treatment efficacy.

Local people have very positive perception towards health post. It is the most popular service: 69.79 percent of them choose health post (see Table 13). Popularity of health post is a result of larger social processes and development projects in Nepal that have, as Kohrt and Harper (2008) suggest, created a Cartesian dichotomy in Nepal, one that suggests that Western medicine is a positive and modern force in Nepal, and it is one that is integral to the development of the country.

Young people having school education are more likely to prioritize health post service**.** Being the scientific and modern practice, it is more reliable. Some other causes of people's positive attitude towards health post are frequent visit of doctors, their referral if needed, cheaper in cost and located in the centre of the village. Eventually, they have positive perception towards hospitals, but due to its unavailability, it has not been the first priority.

Some locals were a bit negative about allopathic medicine and health post, stating that allopathy develops side effects and local herbs do not work after using allopathic medicine. People claim that allopathic medicine is not suitable in every illness – mainly in illnesses caused by supernatural power. The other study done in Thak area, high hill of western Nepal by Parker (1988), also indicated the inefficiency of western medicine. Parker stated that Western medicine is not the proper remedy for every affliction – for example, the illnesses caused by *sindi,* witches and any other supernatural causes**.** Furthermore, nightmares, insomnia, emotional disturbance and general bad luck cannot be treated by the pharmacist, while they seem to be treated effectively enough by traditional practitioners to warrant the continued use of their services. Burghart (1984) also supported the findings that allopathic cures are quick but of short duration, while traditional medical cures are slow but final (a belief identified as a general characteristic of South Asian constructions of 'English' medicine).

The people of old generation and illiterate people are more positive towards *Dhami/Jhankris*. People feel that they are appropriate to heal when the illness is caused by supernatural forces. Many locals have belief that *Bhombos* can heal the problems which cannot be solved by hospitals. Despite the contribution of *Jhankris* in health service in the village, their number and their followers are decreasing. It is mainly due to the establishment of school which created health awareness through health education in the classroom. Similarly, the establishment of health post provided health services (besides providing people health awareness through counseling). Educated youths feel shamanism as a form of superstition. Majority of the informants have negative, but some of them have positive perception towards *Jhankris.*

People feel Lama as the ideal person and have very positive perception. They are more the religious persons than healers, even though they are involved in preventive healing practices. Due to his essentiality in each ritual, people bow their head in front of Lama. Villagers believe that Lamas have adopted divine power that they use for collective welfare.

People are positive towards *Aamchi* due to his contribution to local people. He treats mainly the problem of jaundice, diabetic, poison, snake bites, etc., using local herbs and does not rate the medicinal cost. People are positive by his service but cannot depend only on *Aamchi* due to their inadequacy in number in the local community.

The informants (more than 53 percent, see Table 15) are more likely to choose self-medication as the first attempt for the treatment of all illnesses. Self-medication includes both home remedies and buying medicine from medical shop or taking it from health post. Home remedies are associated with herbal practices. It is decreasing with the lesser number of users and persons who are familiar with the medical herbs and their use. When the transhumant herding practices decreased, herbal practices also decreased with it. The reason is that animal herders are the main collectors of the needed herbs. Some informants denied using herbal practice as they think it works slowly but people want fast recovery. And sometimes these practices may be dangerous as treatment is done without diagnosis. This statement is supported by Banerjee and Bhadury (2012) as they state, irrationally used drugs may lead to serious health hazards, adverse drug reaction and increase in resistance to pathogens.

People are positive towards the practice of self-medication. As they think, it is an easy way to get rid of illness. It is easy way to use and cheaper in cost as well. People are habituated to use medicine rather than to check up first.

Finding on Peoples' Perception on the Illnesses and their Causes

An explanatory model reveals how people make sense of their illness and their experiences of it. This model seeks to understand the basic elements that people associate with certain illness. This model consists of the signs and symptoms by which a particular illness is distinguished, the assumed cause of illness, recommended treatments, how the illness is believed to work inside the body and expected prognosis (Kleinman 1978).

Within medical anthropology, disease/sickness explains the biological or psychological processes, diagnosed and treated within a Western biomedical framework. Illness/healing, on the other hand, explains an individual's and his or her societal psychosocial interpretation and management of sickness, (Kleinman 1978; Waldram 2000; Young 1981).

Hyolmos believe that illness is caused both by natural and supernatural causes. There are two distinct categories of informants who perceive illnesses and their causes differently. Health aware informants such as teachers, local leaders, social workers and people having school education claim that disease is caused by over use of alcohol, cigarette, tension and not maintaining personal hygiene. Generally people having low immunity power, maladjustment in environment, polluted air and water, unbalanced temperature and carelessness get illnesses**.** Informants having no formal education claim that illness is caused by evil spirit.

Illness depends on individuals' immunity power. Persons having low immunity power can be ill frequently. Overload of work and weakness in body cause illness. Some careless people invite weakness themselves using alcohol or smoking or by their negligence in health behavior. It is due to the lack of proper management of their livelihood. The same reasons were also reported in a similar study by Goodwin et al. (1990) in New York that patients with more (disease) symptoms were less likely to follow self-management procedures. Hyolmos believe that aged and female are physically weak compared to young and male and they think that there is a high chance for them to get attacked by diseases.

The next cause of illness they showed is extreme climate. Extreme cold causes common cold, cold diarrhea, cough, joint pain, etc. They drink tea and alcohol to be safe from cold. Irregular and untimely food consumption also causes illness. Fresh food items on time give energy. This finding related to the causes of illness is also supported by Parker (1988). He claims that a common cause of disease is that the body becomes hot or cold, often from eating an excessively hot or cold diet. A hot body is treated with foods or herbs that are intrinsically cold, and vice versa.

The practices among the people for recovery from illness are common in every culture. There are several customs or rituals related to sickness and health being practiced among various ethnic groups. Such belief was found among the Hyolmos who are less conscious in their health. They believe that illness is caused by spiritual forces and it is the result of unluck.

Some old informants who have no formal education pointed out that illness results from the bad deeds of their previous life (*karma ko fal*). Some major diseases like leprosy, T.B. are the result of their bad deeds (sin). They also believe in supernatural causes like *masan pichas, sindi, naag,* etc., which they think cause illness and can be cured only by *Jhankris.* Younger generation people with the background of formal schooling also do not accept this superstitious argument. They know that many diseases are communicable and attack the physically weak persons fast. They are transmitted by sharing clothes, bed, food and through air. Thus people try to remain away from ill persons. The other causes of illness they stated are excessive mental stress and the germs. Tension causes lack of appetite, which creates weakness in the body, and germs cause stomachache.

Findings on the Perceptions of Service Providers to Each Other

There are two types of healers: traditional and modern. Traditional healers include ethnomedical practitioners, Lama, *Aamchi* and *Jhankris*, whereas modern healers are allopathic practitioners of health post and hospital. Each healer has the feeling of both cooperation and competition indirectly. Foster (1978) implies that in general there is competition or antagonism between traditional and modern medicine. In his words: "the evidence is overwhelming that in countries where traditional peoples have had access to modern medicine for a generation or longer, and where this medicine has been of

reasonably good quality, the battle has been won, and scientific medicine is the victor" (p. 304).

Jhankris were found cooperative with senior *Jhankris*, but they have a feeling of competition between/among them with the *Jhankris* of similar rank. It is due to the proud feeling that one is more powerful than the other.

The *Jhankris'* relation with allopathic service providers (HP and hospitals) is not good. This is also proved by the fact that local *Jhankris* have not attended to health post for their treatment. Pigg (1996) states, "Modern medicine is positioned as the eventual replacement for existing modes of healing. Modern medicine thus has to combat healers like shamans. In Nepal, shamans perform the rituals that placate spirits or foil witches; they generally do not give medicines or manipulate the body itself. Their association with spirits and rituals makes them especially potent metaphors for tradition in juxtaposition to the science of 'modern medicine' "(p. 162).

Nowadays their relation is changing, as *Jhankris* have started to refer the cases of accident and wound to hospital and health post. Shamanism is also practiced in hospital bed occasionally. It proves the relationship between both kinds of healers and the strong belief of Hyolmos in both of them. Similar finding was drawn by Beine (2001) in the study of Saano Dumre, who stated that most traditional healers have started to refer to hospital in the cases of *thulo rog*.

Jhankris are positive towards Lamas, *Aamchis* and herbalists. Lamas are positive towards all healers. Lamas focus on the existence of all practices in a cooperative way. He clarifies that betterment of his community health is possible only by the coexistence of all healing practices.

Aamchi is also positive towards all the existing healing practices of Hyolmo community. But he does not refer to *Bhombo*. He states that the modern healing practices are more effective. Despite his balanced perspective, he prioritizes a bit more on allopathic practice.

Health post represents the allopathic practice in the village. The allopathic practitioners are not positive towards *Jhankris* as they cannot treat but consume the precious time of patients up and the case worsens. Allopathic healers do not care about

other practices, but sometimes they fall into problem due to other healers who apply meaningless efforts to heal patients but do not get success.

Findings on Health-Seeking Priorities of the Hyolmos

More than half (53.12 percent) of the household heads prioritize self-medication in the initial stage of illness, because it generally involves home remedies made by locally available medicinal substances. So it is easy and not expensive. None of the villagers were found using self-medication in the next stage of illness when complexity arises.

In the ratio of self-medication, almost same (46.87 percent) number of informants chose health post as the first priority in the beginning of illnesses. When the local health post started to serve at a very nominal cost (NRs. 100 per person for check up and medicine annually) and when literacy rate in the village increased, health post followers also increased.

Among Hyolmos, 22.91 percent informants shared that they go to *Dhami/Jhankri* for the first time. Those who choose them are mainly old people who have no formal education. They claim that many illnesses like *lagu, sindi, masan* etc. can be cured only by *Jhankris* and they have strong belief in *Jhankris* from the remote past.

Only 10.14 percent informants chose Lamaism as only few respondents go to Lama for worshipping different forms of god. Lamaism is more preventive than curative. Lamas are "faith healers who use the power of suggestion, prayer and faith in god to promote healing" (Cockerham 1989, p. 141). The patient who suffers from a mental or physical disease seeks the faith healer.

The least number of informants (5.20 percent) go to hospital in the cities as a first priority. This is because, firstly, they think minor illnesses can be cured locally. There is no hospital in the local area, so they need to travel about at least 40 km up to Melamchi Bazaar or about 100 km up to Kathmandu. Only those who have easy access due to home or relatives in Kathmandu, go to the city hospitals.

They choose the next alternative if the first attempt fails. The users go to a different practitioner if their first priority fails to heal. The ratio of people who go to *Jhankris* increases a little bit and reaches up to 25 percent. Some patients were also found going to *Jhankris* even after consulting health post if they do not get well.

The number of hospital followers increases and reaches up to 22.91 percent in the second stage, with the feeling that the case is serious. The health post followers also decrease by 21.87 percent as people think that health post is just for basic treatment. Only 6.25 percent informants go to Lama in the second stage. It is also in decreasing ratio. If the second attempt does not succeed, 38.58 percent patients go to hospital, 3.12 percent go to Lama, 3.12 percent go to *Jhankris* and only 1.04 percent goes to health post among the remaining informants for allopathic medicine.

When finding about the choice of informants in different stages, the most popular is health post (69.79 percent); the second popular is hospital (66.66 percent), the third is self-medication (53.12 percent), the forth is *Dhami/Jhankris* (51.04 percent) and Lamaism is just 19.79 percent. It shows that the people who use allopathic medicine are increasing and the people who choose traditional healers are decreasing. Pigg (1995, 1996) also discusses the patients using western medicine are increasing frequency due to the spread of education and modernity. The perceived efficacy of western medicine also appealed them. This caused many of her informants to actively question the legitimacy of more traditional, indigenous forms of healing.

Findings on the Factors Contributing to Change in the Medical Choices

Many factors focus on individual characteristics like education, which serves as a critical feature of agency. However, structural factors also have an important role in shaping life chances and choices. Social class, capturing occupation, income, and wealth, as well as age and race/ethnicity are critical structural variables that shape the context in which individuals make lifestyle choices and changes (Cockerham 2005). The contributing factors which brought changes in the study area are discussed below.

Health literacy and self-efficacy are particularly important for health behavior changes (Mirowsky & Ross 2008). Health literacy is possible by education. Education is one of the key factors that have influenced people's medical choices. Bandura (1990) concluded that pre-conditions for change are created by increasing people's awareness and knowledge of the profound threat of illness. Cutler and Lleras-Muney (2010) also focus on education as a major factor to change the health behavior. They state that health behaviors are often cited as a primary cause of the socio-economic status gradient in health because negative health behaviors such as smoking, heavy alcohol consumption,

physical inactivity, and obesity are most common among those with low level of education.

Health behavior of the people of Melamchi Ghyang is found to have changed due to the awareness and education in recent days. After the school was established in 2045 BS, there has been gradual change in literacy situation; and almost fully illiterate society changed into aware society. Now, about 62 percent people are literate, whereby 8.18 percent are SLC passed and 6.34 percent have passed up to +2 level and a few males have also passed bachelor's level. Female's literacy rate is lower (48.74 percent) than the literacy of males (74.5 percent). Adult literacy classes have supported to increase the literacy rate. Along with the increasing literacy rate, persons depending on *Jhankris* are found decreasing. Educated people have started to go to health post for treatment. As a result, allopathic users are found increasing. It has also maintained the personal hygiene, such as hand and cloth washing, and they got the concept and the means of family planning. Rachel (2013) states that the better educated are more likely to practice healthy behaviors. The more educated are the least likely to smoke and most likely to be physically active in their middle age. They are also most likely to make healthy changes overall and better adhere to them. Education also shapes behavioral change after a new diagnosis.

Arcury et al. (2005) include transportation as an enabling factor. They added the measures of geographic access and spatial behavior to the HBM, including distance, availability of transportation and activity space. Their study shows that increased distance to a provider reduces health care utilization. Moreover, there is significant evidence that health care utilization is lower in rural areas compared to urban areas (Blazer et al. 1995, Casey, Kathleen, & Jill 2001). The study area had no transport facilities in the past. According to Jones et al. (2009), the longer travel distances and fewer transportation options available for people in rural areas have lower access to health care in terms of affordability, proximity and quality. Lack of access to affordable transportation is a major contributor to health disparities.

Melamchi Ghyang is recently connected with road transport, which contributed a lot in the easy supply of medical items that are necessary in the village. Now they have easy access up to Kathmandu. *Helambu Sarokar Samittee* now launches ambulance

service. The practice of going to city hospital by helicopter charter among the limited rich people has decreased. Road transport has made easy supply of food stuff and LP gas as the alternative source of fuel, which has decreased the smoke of their fireplace and supported for healthy life. But the supply of packed food items in the village has given negative health impacts to the villagers. Moreover, In all households, transhumant herding (Bishop 1998) has changed to working abroad now. As the study area was isolated in the past, they utilized very limited modern healing options. Now the area is not isolated and the medical practices are influenced by many factors.

Communication is one of the factors which has brought change in medical choice. There is the supply of electricity in the village since 1990. Due to the supply of electricity, television and radio services have been made accessible. Expansion of Dish Home and FM radio has further strengthened communication. Television has contributed to change medical choices and oriented the people (knowingly or unknowingly) towards westernization. People are aware and forward by the influence of radio and TV as they broadcast health-related message and programs. The next popular means of communication in the village is telephone or cell phone. Telephone service developed two decades ago, whereas cell phone became accessible to local people just a few years ago. Now, almost everybody has cell phone service, and everyone can contact their relatives who live in city or abroad and take advice for any health problem, which was not possible before the expansion of these services. The villagers can ask about the presence of doctors in Melamchi Hospital. People can directly talk with *Aamchi* and take advice. *Jhankris* also have cell phone to which they are called from the next village. Means of communication has made the healing service faster and easier now. A study by Bandura (1990) also highlighted the importance of mass media. Bandura states that because of their wide reach and influence, the mass media, especially television, can serve as a powerful means of social diffusion of information regarding health guidelines.

Foreign employment in the village began from the early 1950s, but the circular migrants went abroad in 1970s and 1980s (Bishop 1998, p. 74). First, the people went to Burma for work and then to Assam, Himanchal, Arunanchal, Delhi and many area of India. Some of the villagers are working in USA, UK, Israel, Korea, Hong Kong, Canada, Finland, Dubai, Kuwait etc. Among the foreign employed locals, the members of 46

percent households are in India and more than 8 percent are in US, which has enhanced their economic level to choose healers on the one hand, and medical practices are influenced by western allopathic practice, on the other. The villagers who used to choose *Jhankris* for healing in the past have started to go to advanced hospitals of Kathmandu now. It has increased the people's access to modern medicine. As a result, traditional norms, values and belief system are not functioning properly. Mainly their belief in traditional healers and ethnomedical practices are decreasing. One study in Guatemala also reported similar finding that, in general, it seems that emigration and migrant remittances are improving the people's access to anti-parasitic medicines and curative health care services (Lindstrom, Munoz-Franco 2006) particularly for low-income households (Daniel, López-Cevallos & Chunhuei 2012).

The influence of allopathy in the village seems to have occurred prior to the establishment of health post. The health post has just increased and the locals are habituated to use allopathic medicine after its establishment. Basically the foreign employees, the local teachers and tourists used to bring some general medicines. Now, about 46 percent households shared that they go to health post for the basic health facilities for themselves and for their family members. The health facilities provided by the HP at low cost, duty of the nurse, and the occasional visit of doctors have won the heart of local people. The people, who in the past used to go to traditional healers, have started to go to health post now. People go there first in every minor and major case. The increasing practice of allopathic medicine has decreased ethnomedical practice and people are worried about the loss of this ethnomedical knowledge and self-medication practice. Actually hospital/health post has made the people dependent on modern medical practice.

Over the past six decades, tourism has experienced continued expansion and diversification to become one of the largest and fastest growing economic sectors in the world (Williams 2006). There is similar experience in Nepal. Tourism in Helambu began in the 1970s as the place lies in the Langtang trekking route and Gosainkunda pilgrim route. Both the foreign and native tourists visit in two seasons in a year, September to November and March to May. A few tourists visit in off season too. Tourism brought both economic enhancement and western influence. Sometimes the villagers used to ask

the businessman of the lower part to bring some medicine from medical shops of the bazaar area of Chanaute and Melamchi.

Economic status seems to be the major factor for medical choice. Transhumant herding, the only source of economy till 1970s, is diversified in the present days. Tourism-related business like hotel and lodge were started. The locals started going abroad in search of better opportunities. A person who works in India earns 50 to 60 thousand Nepali rupees and a couple earns about one lakh annually on average. Those who work in other countries were found in much better economic status. All the land was *Guthi* land under Chiniya Lama till 2000. Now, it has been changed into *Raikar*. About 94 percent households have *Raikar* land now. The local vegetables are sold by the villagers in the hostel or in the local market. Some locals are employed in the local area as teachers or construction laborers. All these situations have made the economic status strong, which resulted to change their health behavior. Now, they can afford doctor's fee and medical cost. People can afford about a million rupees for helicopter charter for an event. Economic prosperity has contributed not only to change in medical choice but to faster healing opportunity. *Jhankris* come to a rich person's house in a single call, hoping to get better income.

Link of Hyolmos with city area, basically with Kathmandu, is not new. Melamchi Ghyang and Bouddha Ghyang were developed as sister organizations under the same Guthi controlled by Chiniya Lama's generation. Then the rich local people started to buy land and construct building in Bouddha area, Kathmandu. Now 50 percent Hyolmos have home and 27.08 percent people have land and some of them have relatives in Kathmandu. That link brought changes in Hyolmo culture, and so in medical choices. It has familiarized the locals with urban medical practices (mainly allopathic practice). Some Hyolmos have used homeopathy, ayurveda, acupuncture, yoga, etc., which are not practiced in local Melamchi Ghyang. The same factor of medical changes were also reported in the study in Thak area, high hill of western Nepal by Parker (1988), who states that the link of high hill people with urban area brings changes in medical choices.

Inter-marriage was strictly prohibited in Hyolmo community of Melamchi Ghyang till three decades back. But now, it is a common practice which began in the 1980s when Hyolmo youths started to work abroad and in the city area either to work or

for higher studies. This practice accelerated with the development of transportation and communication. Now, inter-marriage between Hyolmo and the non-Dalit is accepted. It is now represented as an agent of cultural exchange. Some medical practices and solutions of health problem are borrowed and applied to their new home which has changed their traditional healing practices. The next change is due to referral cause made by the relatives of other culture. In fact, inter-marriage has supported to exchange the medical knowledge and practices. The expansion of healing ideas and the support of relatives have contributed to such change. McKinlay (1973 p. 275) adds to highlight the referral cause that "the family, its kinship and friendship networks, influence the manner in which individuals define and act (or fail to act) upon symptoms of life crisis".

Establishment of Langtang National Park could not become the good news for the villagers. It was established in 1976 and Melamchi Ghyang area was incorporated in the park in 1986. Since then, the villagers are not allowed to enter the jungle area to collect any forest products, including herbs. It also created hurdles in transhumant herding. The process of collecting herbs by the herders from the jungle and grassland of high altitude was also stopped. It declined the herbal practice in the community. In addition, community forest users group also strengthened the policy of national park. Once medicinally independent villagers now have to depend on others when herbal practice declined. Now, a very few elder people recognize the herbs and know about their uses. When the popular herbal practice declined, people started shifting to other medical alternatives.

The country's political atmosphere also influences on health behavior. Political arrangements that empower groups by giving them ownership of material resources, information, and decision-making authority foster individual empowerment of group members by providing direct experience in organizing people, identifying resources, and developing strategies for achieving goals (Ewart 1991). But politics has played a very minor role in medical choices in Melamchi Ghyang. There is almost no influence of politics even after the various political changes occurred in the country. They have almost no interest in politics. Nowadays, mainly after the people's movement II (2062/063 BS), the people have shown some interest in it. Politics has connected them with other communities, and they have learnt about further options of medical practices indirectly.

CHAPTER IX:
SUMMARY AND CONCLUSIONS

Summary

Medical pluralism is the practice where a patient has a number of choices for the selection of treatment practices. It is the coexistence of multiple medical systems, each with their own ways of conceptualizing the body, illness, and healing in a single community. Based on the enthusiasm regarding why people follow more than one health seeking strategy and whether there are changes in medical practices along with the influencing factors of change, the objectives of this research included the issues of their present medical practices, efficacy of different practices and the changes observed in their practices along with the factors contributing to the changes in the Hyolmos of Melamchi Ghyang, Helambu, in Sindhupalchok.

This is a mixed type study focusing more in qualitative study carried out in the framework of Explanatory Model of Kleinman (1978), which looks at the universal response to disease, illness, pain and suffering, and identifies the common factors of health and healing practices in various medical systems around the world. It reveals how people make sense of their illness and their experiences of it. The model contains eight specific open-ended questions. I have developed interview guidelines by incorporating his questions for key informant interview. Altogether 30 different potential informants were screened out and selected purposively including service consumers and providers; among them, six non-Hyolmos were also interviewed to crosscheck and to get outsiders' perspectives. Five focus group discussions of different categories of people, including women, were conducted, and six specific cases were also analyzed separately. The participant observations of events were made during the fieldwork. They all provided qualitative data text, whereas quantitative data related to socio-economic and cultural context were gathered through census questionnaire. These two types of data were cross checked for the reliability of research.

The available literatures from the world context to regional, national and Hyolmos context in particular were reviewed to identify the research gap. A conceptual framework was developed and the findings were discussed on the basis of conceptual framework and the theory applied.

Kleinman (1978) has developed a model of medical sectors. On the same basis, Hyolmos' different medical practices are categorized into three broad types – the popular sector, folk/traditional sector and professional sector. The popular sector consists of health care conducted by ill persons themselves, their families, relatives, social network and communities. It includes a wide variety of therapies, such as special diets, herbs, exercise, rest, and baths or over-the-counter drugs. Under this practice, food habit of the locals, sanitation, drinking water, self-medication, exercise, meditation, ethnomedical practices and herbal practices are included in this research.

The local fresh organic food items like *jhamba, syakpa, jyamdor,* vegetables and milk items produced from animal husbandry and the timely use of food items have supported them to be healthy. But now people also have started to use processed food items such as Horlicks, biscuits, noodles, beaten rice, etc.

All the houses are clean inside and outside. Almost all households have toilet facilities, either of permanent type or temporary pit. Helambu was declared Open Defecation Free (ODF) VDC on 10th Ashar 2071 as the 50th VDC of Sindhupalchok district to be declared so. They use the deposit of temporary toilet as manure. There is problem of drinking water due to the lack of proper management, though there is piped water distribution system. The drinking water is neither filtrated nor purified; however, the water is drinkable due to being cold place.

Self-medication, as one element of self-care, is the selection and use of medicines by individuals to treat self-recognized illnesses or symptoms (WHO 1998). It is widely prevalent among Hyolmos. In Melamchi Ghyang, people use both the allopathic and herbal medicines for self-medication. The villagers use different herbal medicines as ethnomedical practices and the most common is *kutki,* ever known and used for fever, gastritis, common cold and cough. The other herbs available in the local area are *jatamasi, nirmasi, panchaunle, yarsagumba, ban lasun, ban satuwa, ban karela, chiraito, bojho,* rhododendron etc. It is a popular practice in Melamchi Ghyang because it is easy, tension-free, cheaper and accepted culturally. For every health problem, 53.12 percent locals first follow the process of self-medication. But this practice is declining due to the lack of the person having the idea of these herbs, lack of collectors and restriction to

collect the herbs by National Park and Community Forest Users Group. Thus this practice is replaced gradually by readymade allopathic medicine provided by health post.

Exercise and meditation are not regular among the local people. They have no proper exercise, but regular walk and movement in hill maintains their exercise. Meditation is only for religious purpose but provides mental peace. Some locals, natives and foreigners meditate in the local Chandra Surya cave where it is believed that Guru Padmasambhava had meditated in the 8th century. Some people meditate in jungle area by making a shed. Hyolmo housing style also protects them from severe cold. Their houses with limited windows are made of mud, stone and wooden plank. There is fireplace at the corner of house to make the house warm. They wear thick long clothes. They often drink alcohol and salty tea frequently to protect their body from cold.

The next medical sector developed by Kleinman (1980) is folk/traditional practice in which healing is performed by non-professional and non-bureaucratic specialists who have been trained informally or are experienced. There are some practices like *Kul puja*, Lamaism, *Dhami/Jhankris, Aamchi* and traditional safeguard system under this category of medical practice.

The different clans of Helambu perform *kul puja (kangsu)* in different ways. It is performed by worshipping ancestor god, thinking that they will be protected or get relief from illness by the blessing of ancestors. It provides them mental strength as they think that it avoids their bad days, makes members prosperous and helps them to maintain peaceful and healthy life. It is performed by Lama in Gumba.

Lamas are religious healers for basically preventive measures. They recite *Tripitak*, perform puja and light the lamp to please god in Gumbas. Sometimes they heal the patient using mantras. The locals have very positive perception towards Lamas and Lamaism as they are the most respected person. Lamas are religious experts and social leaders who play important role in every ritual. They conduct purification process, find good or bad time, predict the patients' future and make the god pleased by worshipping mainly in Gumbas. The locals believe that Lamas have divine power that they use for collective welfare and to avoid evil spirits.

There are *Jhankris (Bhombos)* who are healing the patients affected from evil spirit from time immemorial. The people of Melamchi Ghyang eventually visit the

allopathic healers, consulting the traditional healers first. Many local people go to *Jhankris* for healing because of the faith over them traditionally and they are cheaper as well as easily available in the village. Mainly the elderly people have strong faith over them.

Aamchi is a person who performs curative healing practice in Helambu area and he uses herbs based on a Tibetan text. Many villagers have belief on *Aamchi* to treat problems like jaundice, hypertension, food poison etc. An *Aamchi* provides medicine in low cost. Despite his effective healing practice, all the villagers are not benefitted due to limited number of *Aamchis*.

Though Hyolmos are Buddhist, they have the practice of offering religious gift or dedication, called *bhakal,* to Hindu gods/goddesses. Animal sacrifice is also offered to these gods/goddesses. This practice is decreasing and many informants denied the existence of such practice in the community; but some events were observed though they were rare.

Kakani is the entrance gate of village in which the pictures of gods/goddesses are kept thinking that the evil spirit cannot enter the village crossing the *Kakani,* and the villagers are protected from evil power. Some villagers use mascot as the individual's safeguard. Lama gives a sacred thread to adult and *Dhami/Jhankris* give mascot to children. This practice is decreasing now.

The third sector of medical practices developed by Kleinman (1980) is the professional sector. It involves the highly specialized training and knowledge-based educated health service providers or biomedicine users, where there is formal position of practice. This research also incorporates basically the health post service in the local area, which has promoted allopathic medicine. It distributes 177 kinds of medicine free of cost and rest of the medicine is available in the village at very low cost. Taking membership at Rs. 100, one gets service and medicine for a year. It is more attractive for the villagers due to the frequent visit of doctors. Despite the positive perception of locals, some old informants who have no formal education are not much positive towards allopathic practice by showing its drawback like side effect, immature nurse, and new practice. These people believe that allopathic medicine increases illness if the problem is caused by evil spirit.

Education has played an important role in medical choice to make the local people aware for their healthy life. The local school has contributed to make the people educated. About 62 percent people above six years are literate, and adult literacy classes are running. Education has changed the local peoples' concept for protection of jungle, environmental cleanliness, personal hygiene, use of modern medicine, and family planning.

Patients seek more than one strategy for fast recovery of health problems. 61.45 percent informants shared that they use multiple health seeking strategies due to their availability, 51.04 percent shared due to being cheaper, 50 percent said to get well faster, 42.7 percent said that they have belief on all practices, and 3.12 percent people responded that they use multiple strategies because they have no belief in a single provider.

Hyolmos believe that illness or any misfortune is the result of natural and spiritual cause. The diseases developed in physical body make a person ill. Physically weak people become victimized faster by communicable diseases. Uneducated people neglect more on their health, e.g., by using alcohol and smoking, which causes illness. Aged people and females are physically weak compared to the young and males. Lack of balance in climate and food also cause illness. It is also the result of sinful acts done in previous life and caused by the evil power like *masan, naag, sindi* etc.

To get recovery from these illnesses, 53.12 percent household heads medicate oneself first. And 46.87 choose health post first and 22.91 percent go to *Dhami/Jhankris*. Their first choice was based on their availability in village, acceptance by society and family, and the cost involved. When these first choices fail, they attempt the next alternative. While attempting multiple alternatives, the followers of *Jhankris* were found decreased and the people who choose hospital/health post were found increasing. Accordingly, 38.58 percent people go to hospital, 3.12 percent go to Lama or *Jhankris* and 1.04 percent go to health post for final attempt.

Healers' perception towards other healers is also an important factor in choosing healing service. Generally, a healer plays the supplementary role to the next healer because their collective aim is to make the villagers free from illness but they have the feeling of competition within and between them for their existence. Mainly the traditional and modern healers have antagonist feelings. *Jhankris* perceive other *Jhankris* positively

or negatively on the basis of the hierarchy according to seniority. Junior *Jhankris* often refer to senior *Jhankris* in case of complex problems but the *Jhankris* of similar status have the feeling of competition. Sometimes they play antagonist roles. They are not much positive towards hospital but are positive towards Lama, *Aamchi* and local herbalist. Lamas are positive towards all healing practices. They focus on the coexistence of all practices in cooperative way. *Aamchi* is also positive towards all kinds of practices. Allopathic healers (mostly health post) are found not much positive towards *Jhankris* because they claim that the healing of *Jhankris* makes the patients treatment late, and sometimes it may cause loss of life. Allopathic healers generally do not care about other healing practitioners, but sometimes they face problem due to other healers who apply meaningless effort to heal the patient, which only worsens the case.

Many changes are found in Hyolmo people regarding medical and healing practices. Education has brought about some remarkable changes regarding medical choices. Educated people do not refer patients to *Dhami/Jhankris*; they refer to health post or hospital. Some youths who study higher education in Kathmandu also refer their families, who depended on local shamans in the past, to health post or hospital. Education has decreased the choice of *Jhankris* and increased the number of allopathic users.

Due to the road facility, ambulance service is possible, and people need not charter helicopter with the heavy cost to go to Kathmandu in case of serious illness and in accident cases. Transport has made easy access to hospitals of Kathmandu even for middle class people. It also has insured the regular supply of medicine in the local health post.

All the households have electricity facility, and most of the households have television with Dish Home. There are local FM stations which broadcast health-related programs too. Telephone services along with cell phone have facilitated the local people to get information of distant places. These communication facilities have contributed for the awareness to local people. They have got better alternatives and faster health service through them.

Employment abroad, mainly in India and in other countries, has contributed in people's economic prosperity. They can choose any hospital of Kathmandu for treatment. It has also decreased shamanism. The members of about 46 percent households are in

different places of India like Himanchal, Ladakh, Arunanchal, Assam, etc., for seasonal job. This process has stopped animal rearing as they do not stay at home throughout the year and there is lack of herb collectors. Therefore, the medical choice of people changed mainly into allopathic practice.

Helambu is a tourist area where many foreign and native tourists visit every year. It has contributed to people's economic prosperity on the one hand and has exposed western medicine on the other hand. The other economic sources such as job, selling goods, farming, animal husbandry, etc., have gradually made the local people more prosperous in recent days; and thus their access to advanced hospitals of Kathmandu has increased. The villagers can also take the *Jhankris* or *Aamchis* facility in a single call.

After the health post was formally established in the village in 2011, the villagers' first choice for healing became health post. The occasional doctors' visit in the health post has benefitted the villagers more. This facility has decreased *Jhankris* practice, ethnomedical and herbal practices.

The people of Melamchi Ghyang use allopathic medicine due to the urban impact. Half of the households have home and 27.08 percent households have land in Kathmandu. The villagers visit Kathmandu as they have relatives in the city. Some of the villagers are involved in business or study in the city. This link has influenced the use of western medicine in their medical practices.

Inter-marriage is new but popular practice among the Hyolmos of Melamchi Ghyang: 82.29 percent HH heads accepted that inter-marriage is now a common practice in their community. It is due to modern education, transportation, communication and foreign employment, which has also caused diffusion of different medical practices as well as changes in their traditional medical practices.

When the forest area of Melamchi Ghyang was incorporated in Langtang National Park in 1986, the villagers were prohibited to enter the jungle area to collect forest products. Dhupu Samudayik Ban Samittee (local Community Forest Users Group) further controlled the use of forest products. As a result, herbs collection was also controlled and the herbal practice decreased.

Conclusions

People in Nepal have utilized several medical and healing practices at a time based on availability and access to get well soon and often mixed the use of traditional and western practices together. Timely use of organic foodstuff, vegetables and milk products; proper management of waste products; pure drinking water, immunization, bodily exercise and meditation maintain the health of rural people. Plural medical practices are widely prevalent due to their belief on many health service providers, easy availability, cultural acceptability and people's desire for faster recovery from illness.

Conclusions on the Existing Medical Practices

Availability, accessibility, cost of medicine, assurance of recovery and beliefs in multiple providers are the leading factors that allow people to follow plural medical practices. The lack of belief on single service provider is one of its factors. Faith healing, basically by *Jhankris,* is predominantly associated with lack of health awareness, lack of education, superstition and older generation populace. Lamaism is a more preventive practice followed by Buddhist people but is less appropriate in many curative illness episodes. The practice of *Aamchi,* who provides medical service according to Tibetan healing system, is also a popular practice in the hill and Himalayan area of Nepal. Prayer, worshipping, religious acts and traditional safeguard customs promote the will power psychologically and contribute to be away from illness and help in faster recovery, though these practices are not scientific.

Self-medication is a popular practice in the rural areas of the third world countries, which mainly involves the use of home-made herbal medicine for the recovery of any illnesses. The high degree of popularity of self-medication is the result of lack of medical experts. Now, people medicate their own selves using allopathic medicine when the facilities of health post and medical shop are available nearby. Immunization process and the use of allopathic medicine are increasing due to education and awareness.

Conclusions on Peoples' Perception Regarding the Efficacy of Medical Belief and Practices

People perceive health as the balanced condition of body as well as mind, and its imbalance is illness which results from both environmental and spiritual causes. The seriousness of illness differs from individual to individual based on immunity power, age,

sex and lifestyle. Accordingly, people can be victimized more or less based on such factors. Educated and aware people believe that illness is caused by naturalistic causes like unfavorable climate, polluted environment, carelessness and bad habits, whereas unaware people believe in mysterious (personalistic) causes such as witch, evil eye, bad fortune and supernatural evil power. Some old and illiterate people have the belief that bad deeds (karma) are the causes of illness, whereas educated people believe it as the result of transmission from person to another. Illnesses are categorized into two broad categories in terms of peoples' perception regarding treatment efficacy. The illnesses which can be cured locally are minor illnesses and the major ones cannot be cured easily in the locality. Some major illnesses of the past have turned into minor ones now because of the possibility to cure them with certain course of medicine.

Each healer has both cooperative and competitive feelings towards other healers. *Jhankris* have competitive feeling towards other *Jhankris* of the same status but they cooperate and support the senior ones. Their perception towards allopathic practitioners is somehow antagonistic. But in the recent days, *Jhankris* have referred the patients to hospital, and the acts of shamanism have been found in hospital beds. These incidents indicate the changing relationship between *Jhankris* and allopathic practitioners.

Though many people have positive perception on allopathic practice due to its efficacy, reliability, low cost, modern, scientific and institutional chain relation, hospital is not the first priority of villagers due to its unavailability in the village. Some are not positive towards it because of its side effects. Himalayan people have a strong faith in *Aamchi* only in the case of some particular health problems like jaundice, sinusitis, food poisoning, diabetic mellitus, and snake bite.

Conclusions on the Changes in Medical Choices and the Factors Contributing to the Change

Various factors have contributed to bring changes in the perception of health service consumers and provides. Basically, education and awareness by the establishment of school and adult literacy classes have contributed in the transformation of medical practices. The traditional faith healers, who were widely popular in healing in the past and got due respect because of their service to the villagers, are still prevalent in the village area in decreasing ratio along with the increasing medical alternatives. They are

still prioritized by uneducated old generation people in the illnesses caused by supernatural power, but the educated people think it just as superstition. Establishment of health post, restriction in the entry to jungle area by community forest user group, establishment of national park and lack of human resource to collect herbs have enforced to decrease the popular herbal practice in the Hyolmo region that it is the storehouse of herbs; but some people dislike using it because of its slow recovery potential and chances of danger when used without diagnosis.

Few people went to hospital in the initial stage due to the cost factor and distance, but many of them are compelled to go there in later stages for final hope despite its cost, tension and distance. Those who have easy access to city hospitals go earlier, and the existence of well-equipped health institutions, frequent visit of doctors for treatment and the cheaper and reliable service have triggered the popularity of allopathic medical practices in modern days.

Transportation and communication have connected the service providers of all categories and ensured easy access of people to city hospitals, ambulance services and various health service-related information. Foreign employment, tourism and establishment of health post/hospital have spread the western medicine into local healing systems, which has ultimately decreased the traditional healing and ethnomedical practices. The job, business and remittance have strengthened the economic status of local people and increased the access of alternative medical choices, faster and better healing service and transformation of health behavior in totality. People's link with city area, inter-marriage practice, and political changes also has brought change in medical practice through the expansion of horizon in opportunities. Herbal practice has been influenced when local forest was handed over to the community forest uses group and national park prohibited the collection of herbs.

When the first attempt of curing fails, then the choice of health seekers shift to the next stage. The followers of allopathic medicine increased and those of traditional healing system decreased in the subsequent stages of illness.

ANNEXES

Annex 1. Household Census Questionnaire

A. Introduction

1. District: 2.VDC

3. Ward: 4. Village/Cluster

5. Household Number : 6. Household Head:

7. Sex : 8. Caste / Ethnicity:

9. Religion :

10. Respondents Name:

11. Age :

12. Birth Place:

13. Relation with household head:

B. Individual and Family Information

Name	1.M 2.F	Age (Completed yrs)	Education (Completed Level and institution)	Marital status 1. Married 2. Unmarried 3. Divorced 4.Widow/Widower 5. Separated	Age of marriage	Occupation	If any Members gone out of country, duration & present status
14	15	16	17	18	19	20	21

C. Family and Social Status

22. Who is the head of your family?

(a) Father ☐ (b) Mother ☐ (c) Son ☐ (d) other (specify)

23. Types of Family

(a) Nuclear ☐ (b) Joint ☐ (c) Extended ☐

24. Types of Marriage in your community.

(a) Arrange ☐ (b) Love ☐ (c) Marriage by elopement ☐

(d) Others (specify) ☐

25. Is there polygamy Practices?

(a) No ☐ (b) Yes -: Polygamy ☐ Polyandry ☐

26. Is there inter- marriage practice?

(a) Yes ☐ (b) No ☐ (c) Rare ☐

27. What do you think the appropriate age of Marriage?

(a)Below 15 years ☐ (b) 16-20 years ☐ (c) 21-25 years ☐

(d) Above 25 years

28. Why this age appropriate for marriage?

(a) Tradition ☐ (b) Physical maturity ☐

(c) Away from disease & illness ☐

29. What Religion do you follow?

(a) Hinduism ☐ (b) Buddhism ☐ (c) Bon po ☐

(d) Others (specify) ☐

30. What are the festivals you celebrate? ☐

(a) Dashain ☐ (b) Tihar ☐ (c) Lhosar ☐

(d) others (specify) ☐

31. What is your main god/goddess?

(a)_____(b) _____ (c)_____(d) _____

32. Who is your main Priest?

(a) _____(b)_____ (c)_____ (d) _____

33. Do you have idea about means of family Planning?

(a)Yes ☐ (b) No ☐ (c) Very Few ☐

D. **Economic Status**

34. Types of houses

(a) *Pakki* ☐ (b) *Kachhi* ☐ (c) *Kachhi-Pakki* ☐ (d) Thatched Hut ☐

(e) Others (specify) ☐

35. Do you have your Hotel/Guest house/Lodge/ Restaurant?

(a) Yes ☐ (b) No ☐

36. If yes, mention the monthly earning from these hotel/ lodges.

(a) Less than Rs. 3000 ☐ (b) 3000-6000 ☐ (c) 6000-10000 ☐

(d) 10000 above ☐

37. When do you know, the tourist started to come?

……

38. Foreign or Native tourists?

(a) Foreign-country ☐ (b) Native ☐

39. Season for tourist.

……..

40. Land

(a) Own ☐ (b) Dual Ownership ☐ (c) Others land tilling ☐

41. Land occupied on *ropani*

(a) Less than 5 ☐ (b) 5-10 ☐ (c) 10-15 ☐ (d) 15 above ☐

42. Major Agro-production

(a) ……. (b) …… (c)……. (d)……..

43. Irrigation Facility

(a) Yes ☐ (b) No ☐

44. Use of Production

(a) For Livelihood ☐ (b) For Feast and Festivals ☐ (c) For Selling ☐

(d) Others (specify) ☐

45. How many months can your family survive with own sources?

(a) Up to 3 months ☐ (b) Up to 6 month ☐ (c) Up to 9 month ☐

(d) For the whole year ☐ (e) Surplus ☐

46. If not enough for whole year, what health related difficulties you face?

……

47. How do you manage the deficit food?

(a)Agricultural labor ☐ (b) Trade/ business ☐ (c) Labor in others ☐

(d) Loan ☐ (e) other (specify) ☐

48. Livestock ownership

☐

(a) Cow ☐ (b) ox ☐ (c) he buffalo ☐ (d) buffalo

(e) pig ☐ (f) yak ☐ (g) chicken ☐ (h) duck ☐

(i) Others (specify) ☐

49. Job and Institution

(a) No ☐ (b) Yes ☐ If yes what intuition?…… ……

50. Years of Employment

……..

51. Monthly Earning.

……

52. Do you have pension and other income?

(a) No ☐ (b) Yes ☐

53. If yes, monthly income ☐

54. Foreign employment

(a) No ☐ (b) Yes ☐ If yes, income and duration ☐

E. **Fuel Consumption Pattern**

55. Source of cooking fuel

(a) Firewood ☐ (b) Electricity ☐ (c) Kerosene ☐

(d) Cow-dung ☐ (e) LP Gas ☐ (f) Bio gas ☐ (g) Solar ☐

(h) Others (specify) ☐

56. Source of lighting

(a) Electricity ☐ (b) Kerosene ☐ (c) Bio-gas ☐ (h) Solar ☐

(e) Others (specify) ☐

F. Religion and Rituals

57. What Rites and Rituals do you follow?

(a) Traditional ☐ (b) Religious ☐ (c) Modern ☐

(d) others (specify) ☐

58. Who Conducts there rites and rituals

(a) Priest ☐ (b) Head of Household ☐ (c) Social Leader ☐

(d) Others (specify) ☐

59. Is there any change you feel in rites and rituals?

(a) No ☐ (b) Yes ☐

60. If yes, what are the changes?

……

61. What do you think are the Causes of changes?

(a) Education and awareness ☐ (b) Development (c) Tourism ☐

(d) Others (specify) ☐

62. How do you name your child?

(a) Birth time basis ☐ (b) Birth day basis ☐ (c) Others ☐

63. Religion you follow and its features.

……

64. Changes appeared on religious practices.

……

65. Who are the respected persons in your society?

(a) Educated ☐ (b) Religious ☐ (c) Witchcrafts ☐

(d) Wealthy ☐ (e) Others (specify) ☐

G. **Health and Hygiene Status**

66. What is the Major staple food?

……

67. Facilities and sources of drinking water.

(a) Tap ☐ (b) river ☐ (c) pond ☐ (d) other (specify) ☐

68. Facilities of Toilet

(a) No ☐ (b) Yes ☐

69. If Yes. What types of toilet do you have?

(a) Temporary pit ☐ (b) *Pakki* toilet ☐

70. If no, where do you go?

(a) Jungle ☐ (b) Riverside ☐ (c) barren land ☐

(d) Others (specify) ☐

71. Belief and practices on

(a) Modern hospital ☐ (b) health centre ☐ (c) Lama ☐

(d) *Aamchi* ☐ (e) *Dhami*/ *Jhankri* ☐ (f) Others (specify) ☐

72. Facilities and servicers given by them.

……

73. Satisfaction on their personal behavior:

(a) Satisfied ☐ (d) less satisfied ☐ (e) dissatisfied ☐

74. Changes on their behavior

……

75. Changes on your healing behavior practices:

……

76. Where do you go when you feel sick?

(a)Modern hospital ☐ (b) Health center ☐ (c) Lama ☐

(d) *Aamchi* ☐ (e) *Dhami Jhankri* ☐ (f) others (specify) ☐

77. If you go on more than one providers, why?

(a) Beliefs on all ☐ (b) No belief in single ☐ (c) To get well faster ☐

(d) Referral cause ☐ (e) Others (specify) ☐

78. Why do you choose them?

(a) Easily available ☐ (b) cheaper ☐ (c) Lack of alternatives ☐

(d) Belief ☐ (e) Others (specify) ☐

79. What is the common disease/illness in your locality?

……..

80. Do you follow self-medication practice?

(a) Yes ☐ (b) No ☐

81. If yes, in what health problem you follow? What are the substances?

……

82. Do you feel any changes in medical/health practices?

……

THANK YOU

Annex 2. Healing Practices on Hyolmos

Focus Group Discussion (FGD): Checklist

Background of Informants: List of the participants, their sex, caste/ethnicity, education, occupation, religion etc.

1. Who participate, where and why?
2. What do you think is health, sickness and illness? What do you do for your healthy life? What are the aspects about health awareness? Why do you think has caused your problem? Why do you think it started?
3. What medical/ healing practice do you follow presently? What were the practices before 30 years? When did they start? Who started them first? What changes are found in it? What are the causes of these changes? What kind of treatment do you think you should receive? What is the most important result you hope?
4. Why these practices are followed in this community? How are they practiced? What procedure do they follow? What are the materials needed for the healing? At what time do they practice?
5. Why not other practices are continued? What factors have made for their continuity or discontinuity?
6. Among the various practices which is the most practiced? Why? Why not others? What are the reasons of medical choices?
7. What socio, political, economic, and educational and infrastructure related events brought changes on the health behaviors and medical practices? When they started to change? How?
8. What is the trend of the change on medical practices? Where did they go and what did they do in the past? What do they do at present? Where do you go for healing/ treatment now? What factors have led to go there to heal? Who goes where and why?
9. Why do the local health centers refer to go advanced and hospital for further treatment? What cases are referred? Where mainly? Is it frequently or rarely? Do the traditional healers refer to go to hospital or to next healers? Are there such events? Do the patients get well later?
10. What are your expectations related to health service? What further facilities and changes do you want? What is you recommendation? Why these changes are needed?

Annex 3.Participants of Focus Group Discussion

FGD 1. 15 January 2014, People taking rest in Public Gumba (All Hyolmos)

1. Ang Chhiring Hyolmo
2. Pema Tasi Sherpa
3. Lanam Lama
4. Kami Sherpa
5. Dawa Dolma
6.Dawa Jangmu
7. Karsang Dolma

FGD 2. 17 January 2014, Teachers of the local School (both Hyolmos and Non Hyolmos)

1. Karma Sherpa
2. Indra Dev Yadav
3. Rudra Kumar Shrestha
4. Chandra Prasad Upreti
5. Padam Bahadur Aryal
6. Pasang Shyangba
7. Raj Kumar Shrestha
8. Rajan Niraula
9.Santa Upreti
10. Kamala Aryal
11. Tika Ram Limbu

FGD 3. June 20, 2014, Villagers at public place after the meeting of forest users group

1.Renjen Sherpa
2. Dawa Norbu Sherpa
3. Dolma Lama
4. Chhiring Sherpa Ghale
5. Pasang Sherpa
6. Nima Dorje Sherpa
7.Dawa Rinji Sherpa

8.Damai Lama

FGD 4. January 24 ,2014, Mothers Group (All Hyolmo Female)

1. Nima Dolma
2. Khando Sherpa
3. Dolma Hyolmo
4. Lakpa Hyolmo
5. Pema Sherpa
6. Shree Devi Sherpa
7. Nambur Sherpa
8. Karchung Hyolmo
9. Dawa Dolma Lama

FGD 5. February 2, 2014 People attending on adult literacy classes (both male and female Hyolmos)

1. Sher Jangbu Lama
2. Karsang Sherpa
3. Karkyap Lama
4. Jangmu Sherpa
5. Karchung Lama
6. Dawa Sherpa Hyolmo
7. Phurpa Sherpa Hyolmo
8. Phincho Pasang Lama
9. Chhiring Sherpa
10. Urgen Lama
11. Khando Sherpa

Annex 4. Checklist for Key informants' interview

a) Introduction of key informant

i) Name:……..... ii) Age:……

iii) Sex:…… iv) Marital status:……

v) Occupation:…… vi) Education:……

b) How do you understand as body, spirit and life?

c) What is the belief about disease illness, sickness and health?

d) What different medical/ herbal practices are followed presently?

e) What curative medical practices are followed presently?

I) *Dhami / Jhankri*

Who are they? Where are they available?

Why do you follow? Why and how they are appropriate?

In what problem are they appropriate? If not, why?

What are their procedures? How do they treat?

What things do they use in their practice?

When? At what time/day do they prefer to practice mainly?

II) *Aamchi*

Who are they? Where are they available?

Why do you follow them? How they are appropriate?

For what disease are they useful? If not, why?

What procedure do they follow?

What things do they use in this practice?

When? At what time/day do they prefer to practice mainly?

III) Self-medication

In what illness is it commonly used?

What medicine/ substance are used in different health problem?

How are they used?

Where are they available?

Who recognizes? Who keeps? How they are kept?

When did this practice start?

Is it costly or not?

How reliable is it?

IV) Ayurveda

Who practices? Since when was it started? For what disease is it used?

Why they are in use? Why people go to them? If not, why?

Where are these practices available?

What medicine do they use?

Where they are brought from?

What is the cost to be bore by patient?

What is its reliability?

V) Homeopathy

Who practices? Since when was it started? For what disease is it used?

Why they are in use? Why people go to them? If not, why?

Where are these practices available?

What medicine do they use?

Where they are brought from?

What is the cost to be borne by patient?

What is its reliability?

VI) Unani

Who practices? Since when was it started? For what disease is it done?

Why they are in use? Why people go to them? If not, why?

Where are these practices available?

What medicine do they use?

Where they are brought from?

What is the cost to be borne by patient?

What is its reliability?

VII) Allopathic Practice

Who practices? Since when was it started? For what disease is it used?

Why they are in use? Why people go to them? If not, why?

Where are these practices available?

What medicine do they use?

Where they are brought from?

What is the cost to be borne by patient?

What is its reliability?

VIII) *Jyotis*

Is there the culture of jyotis?

If yes, who are they? Individual learners or practiced since ancestors? If not, why?

How are they related to health and illness?

What do they do? When, how and in what cases?

What things do they use?

What is their reliability?

IX) *Guru /Purohit* /Lama

Is there the culture of guru/lama/ purohit?

If yes, who are they? Individual learners or practiced since ancestors? If not, why?

How are they related to health and illness?

What do they do? When, how and in what cases?

What things do they use?

What is their reliability?

X**) Yoga/ Exercise /Meditation**

Is there such practice? Why? Why not?

What is done and how?

Who teaches? Or individuals do themselves?

For what problem/disease is it done? Is it curative or preventive solution?

Where do they go for exercise/ Yoga/Meditations? In which place?

Is it regular or occasional practice?

What is its effectiveness?

XI) *Kulpuja*

Who performs? In what disease is it done? What is the duration of puja?

At what time/date/day/season is it done? What is the duration of repetition?

Where is it done at home, Gumba or any where?

How is it done, either collectively or individually?

What things are required?

What is the cost and Effectiveness?

XII) Surgery

Do you prefer surgery?

Why, why not? Is it interest or compulsion?

In what disease is it done?

Where they go for?

XIII) *Bhakal*

Who performs? For what problem/sickness is it done?

At what time/date/day/season is it done? What is the duration of repetition?

Where is it done at home, Gumba or any where?

How is it done, either collectively or individually?

What things are required?

What is the cost and Effectiveness?

What changes or differences have been found after the ritual?

XIV) Japanese Healing/ Acupuncture/Acupressure

Is there such practice? Why? Why not?

What is done under it? Who teaches?

For what problem/disease is it done?

Where do they go for?

How is it done?

Is it regular or occasional?

What is its effectiveness?

F) What preventive measures do they follow?

1) Balanced diet

Do they know what is it? How do they know?

What food items are included under it?

How do they get them?

Who uses, who don't use? Why?

2) Energy giving food/ medicinal food

What are they?

How do they know? When do they know?

What does it work?

How do they work and how do they feel?

Is it reliable? How?

3) Immunization

Who immunizes?

When? When did it start?

Do they accept easily?

What concept do they have on it?

Why they do it? If not, why?

4) Fasting

Is there the culture of fasting?

For what purpose is it done? If not, why?

Who does? Both male and female? or anyone?

Is it compulsion or choice?

How is it done? Full or semi fasting?

What belief system do they have on it?

When was it started? (History)?

5) Other practices for the prevention from illness

Do they wear special clothes to protect from cold?

Do they use *jantar or Buti?*

Is any program launching for awareness and educating people?

Others?

g) Variables of the reason for choosing the particular practices:

1) Economic Status

What are the sub systems of economy in local level?

How does economy determine the medical choice?

Why is it considered a main factor?

What economic status plays what role?

What are the indicators under economy?

Where do service consumers go on the basis of economy?

What changes in economy after the years are observed? How has it effected in medical practices?

2) Social status

What factors determine the social status?

How do social factors determine the medical choice?

Why is it considered a factor?

What social status plays what role?

What are the factors under social status?

Where do service consumers go on the basis of this status?

3) Educational status

How do people get education?

Who are educated people? Formal or informal education?

How does education play the role?

Where do educated people go? Why?

Do they influence other? How? Why not?

Since when, education played the role in medical choice?

4) Cultural reason

What cultural reason plays role? (Norms, values, traditions, customs, usage)

How does it play?

To whom does it effect?

What cultural traits influence on health belief system?

What religion plays the role?

How is religion and medical choice interrelated?

How this is became a linking factor?

Since when, it started to play role?

5) Access of service consumer

What access do they have?

What access they do not have?

When did it start?

Where did people go earlier?

Which service is easier? Which is more popular?

Why do they choose the provider?

6) Transport/Communication

How transport and communication influences on healing/medical choices?

Since when did it start?

Why are they important?

7) Referral Cause

Who refers? (Neighbors, Family, Friends, educated person)

Why do they refer?

How is their referral important?

Where do they refer mainly?

8) Western Impact

Is there modern /western impact?

How and why are they influenced?

What are the factors of this impact?

9) Which treatment is more reliable among them? How? Why?

h) Changing patterns

What changes on medical healing practice do you observed before 10/20/30/50 years?

Why these changes came to exist?

How they changed?

Any political changes, people's movement have changed it? Why? How? Why not?

What and how road construction brought changes? Why?

What are the changes before and after establishment of sub health post/ hospital? Why?

Why are the changes before and after electricity supply remarkable? How?

How have telephone/ mobile service brought changes? What are they?

How the establishment of school brought changes? Why?

What are the changes before and after beginning of trekking route/ tourism? How?

What are the changes before and after overseas employment? How?

How are their choices observed?

Are there changes observed on everybody or on particular person?

What are the changes on healers' choice?

What are the changes on medical substances? Healing equipment?

Why are there changes on local service providers' behavior?

What are the changes on health belief system? How did it bring change?

What are the changes on healing process?

What are the changes on referral system?

What are the changes on reliability of treatment?

How their system changed?

Why those changes observed?

i) Why these practices are on your preference? Is it obligation or interest to choose them?

j) Do you follow single practice or multiple practices at a time? If yes what? If not, why?

k) How do you make the belief system on it?

l) Are there any changes on these practices, either modification on same system or to choose new option? What are they?

m) Why these changes are observed? What are the factors they bring the changes?

n) From when did these changes start? Which date? Which events? Why?

o) Do you think these changes are good or bad? What are its effects?

p) Are there any unintended changes? Why these unintended changes came to exist? How these changes can be reduced?

q) In your opinion, which is more effective medical/ healing practice?

r) Why that is more effective? Do you have any experience about these practices?

s) What are the strengths, weakness and challenges of that practice?

t) What is your expectation about the practices form public people? central government? local government ?

u) What recommendation would you offer on different medical practice?

Thank You

Annex 5. Checklist for Case Study

1) Introduction
   a) Introduction Name
   b) Age
   c) Sex
   d) Marital status
   e) Occupation
   f) Education
2) Medical practices in the past
3) Medical practices at present
4) Causes of these practices at present
5) Major changes
6) Minor changes
7) Factors of changes
8) Process of changes.
9) Consequences of changes.
10) Future of that practice, leadership numbers of followers, belief, and possibility
11) Support given by others.
12) Your recommendation.
13) Any particular experience regarding that practice.

Annex 6. List of Annex Tables

Annex Table 1: Use of Agro-production

S. N.	Uses	Households	Percentage
1	For livelihood	90	93.75
2	For festival	78	81.25
3	For selling	18	18.75

Source: Fieldwork 2014

Annex Table 2: Distribution of HHs by Animal Rearing

S. N.	Animal	HH
1	Cow	30
2	Ox	4
3	Buffalo	6
4	Yak	3
5	Chauri	3
6	Goat	2

Source: Fieldwork 2014

Annex Table 3: HH Members gone abroad to Work

S. N.	Country	HH	Percentage
1	India	44	45.83
2	US	8	8.33
3	Israel	5	5.20
4	Korea	5	5.20
5	UK	3	3.12
6	Hong Kong	2	2.08
7	Canada	2	2.08
8	Finland	2	2.08
9	Dubai	2	2.08
10	Kuwait	2	2.08
	Total	**75**	**78.12**

Source: Fieldwork 2014

Annex Table 4: Distribution of HH by the Family Size

S.N.	Types of family	No of HH	Percentage
1	Nuclear family	69	71.87
2	Joint family	27	28.12

Source: Fieldwork 2014

Annex Table 5: Concept of Family Planning

S. N.	Response	No. of respondents	Percentage
1	Yes	75	78.12
2	No	21	21.87

Source: Fieldwork 2014

Annex Table 6: Head of the Family and Decision Making

S.N.	Head/ Decision maker	No.	Percentage
1	Father	55	57.29
2	Mother	23	23.96
3	Both (Collective) Decision	22	22.91

Source: Fieldwork 2014

Annex Table 7: Priority of Marriage Practice by HH Head.

S.N.	Types of marriage	Response of HH head	Percentage
1	Love Marriage	65	65.70
2	Arrange Marriage	24	25
3	Both love cum arrange	7	7.29
	Total	96	100

Source: Fieldwork 2014

Annex Table 8: Practice of Inter-marriage

S.N.	Response	Number	Percentage
1	Yes	79	82.29
2	Rare	9	9.37
3	No	8	8.33
4	**Total**	**96**	**100**

Source: Fieldwork 2014

Annex table 9: Facilities of Toilet in the Study Area

S.N.	Types of toilet	Households	Percentage
1.	Temporary pit	69	71.87
2.	Pakki	21	21.78
3.	Pakki (under construction)	6	6.25
4	**Total**	**96**	**100**

Source: Fieldwork 2014

Annex Table No. 10 Home and land owned in Kathmandu

S.N.	Status	Respondents	Percentage
1	Home	48	50
2	Land	26	27.08

Source: Fieldwork 2014

Annex Table No. 11 Source of fuel for cooking

S.N.	Source	User Households	Percentage
1	Firewood	96	100
2	LP Gas	20	20.83
3	Solar	2	2.08

Source: Fieldwork 2014

Annex Table No. 12 Source of Lighting

S.N.	Source	User Households	Percentage
1	Electricity	96	100
2	Solar	10	10.41
3	Kerosene	12	12.5
4	Charger/ Emergency light	9	9.37
5	Candle	2	2.08

Source: Fieldwork 2014

Annex 7. Glossary

Bhakal	The promise made by person wishing to offer religious gift or dedication to some god/goddess
Bhombo	Shaman (*Dhami /Jhankri*) in Hyolmo language
Bokshis	Witch-women
Chauri (Zomo)	Female crossbreed, the offspring of domesticated yak and cow
Dharsing	Religious flag under Buddhism erected on house yard of Hyolmos
Ghewa	Commemorative funeral rite held in honor of the demised
Gode	Temporary shelter made of bamboo and mats in which herding family live with animals (Goth)
Gumba	Lamaist Temple
Ilaka	A political area comprised of 9 to 17 VDCs
Jari	Culture to marry others wife by paying certain fine determined by the society
Jharfuk	Combined healing practice of both herbal and faith healing
Jyamdor	Liquid drink made by mixing tea and flour of roasted grain
Kangsu	*Kulpuja* (worshipping of ancestral god by Hyolmos)
Khada	A colorful piece of holy cloth offered as present like garland in Buddhist culture
Kharka	Grassland area
Kul Devata	Ancestor god
Lama Bidhya	Buddhist education system of getting education in Gumba
Masan	Graveyard spirit
Mheme/Ibi	Respected term used for old male and female respectively
Nak	Female yak
Narha	A festival celebrated in Shrawan month
Raikar	A type of land under the government control, the people use it paying certain tax
Remittence	Money earned from foreign employment
Rimpoche	Buddhist religious guru, incarnation of Buddha, who is considered as Shiva Mahadev under Hinduism

Rongwa	Non-Hyolmo people of low land
Sindi	Soul of dead body
Syalgar	A full bottle of alcohol offered as present on some auspicious occasion, like marriage
Syakpa	Food item mixture of potato and wheat flour
Tashi Delek	Greetings like 'Namaste' in Hyolmo language
Temka	Culture to add food item more than one time to make it pure
Torma	Ritual dough statue made of flour which represents deities in Buddhist rituals
Tungna	A musical band used by Hyolmos made of string and the wood of rhododendron
Zopkio	Male hybrid produced by the cross of yak or naak with bull or cow

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