



A STUDY ON SOCIO-CULTURAL ASPECTS OF
SELF MEDICATION AND ITS IMPACT ON
ESSENTIAL DRUG SCHEME AT THE LOCAL LEVEL

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A STUDY REPORT ON SOCIO-CULTURAL ASPECTS OF SELF -
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AT THE LOCAL LEVEL.

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We hope, this study will help in formulating certain policies, programmes besides research work in the different health related field especially essential drugs.

Dr. Kumud Kumar Kafle

Ritu Prasad Gartoulla

FOREWORD

The study on "Socio-cultural Aspect of Self-Medication And Its Impact On Essential Drug at the Local Level" was conducted by two staff members of the Institute as Principal Co-ordinators. The report is based on data collected in the district of Makawanpur.

I hope this study will have implication for policies, programmes and research purposes in the field of health.

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A study on Socio-cultural Aspects of Self-Medication and its
Impact on Essential Drug Scheme:

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SECTION I,

NEPAL

A Brief Introduction :

A. History

The name Nepal was coined on different grounds. The sources of history of Nepal, legends-dictum and different epigraphies suggest that Nepal was a big well (which was only supposed the Kathmandu Valley as a whole Nepal) with water, where, Manjushree, a social worker, made the way to pass the jammed water to cross the valley. Some of the sources suggest that Lord Krishna killed a powerful ghost and made Kind during his visit. 1

The history of Nepal goes with the history of migration. The aborigin people were Gopala and Mahishpala (cow and bufallow herdees) who came to the Kathmandu valley with their animals for animal hussbandry from India and Shepherds from Tibet with their sheep. Among the Gopala & Mahishpala, who were settled after their migration to Nepal became the king to rule this society and people. They had no Judiciary, administrative and other social organizations.2

While Avira, who entered into Nepal, from South India during the Muslim Invasion there, they came with the limited economic resources, slightly developed tools and technologies and started agricultural system along with the animal husbandry which was purely like the feudalistic mode of production and system. They fought against the Gopala and Mahishapala and won, then became the king and ruler of Nepal.

Then the Mongloid group, i.e. Kirata came from Tibet and Burma as well as Northern Part of India settled here with the Aviras.

Lichhavis who migrated from different areas of the world, especially from Asian continents, ruled Nepal for a long period of time. Lichhavis attacked Kiranta ruler and ruled over.

Priests, scholars (Sanskrit), and Vaidhya were admitted as consultants to suggest the kings and nobles. Health care was provided by these priests, vaidhayas in the traditional form.

In the Malla period Nepal was divided into several petty states. Each state had separate kind of systems, because of the various kinds of rules.

After Malla when King Prithivi Narayan Shah headed on the throne of Gurkha Kingdom, tried to integrate Nepalese fragmented society into one.

The unification was completed by 1815 when a treaty was signed by two countries i.e. Nepal and Honorable East India Company. By then, the Socio-economic, Politico and religious-cultural development was started all over the country making decentralization programme and Judicial states.

The revolution in 1951, brought democracy in Nepal and whatever the facilities are developed today was opened after this revolution. Health, economic, political and other structures were emerged and changed.

In 1961, Panchayat System came banning all the parties with partyless political Characteristics.

Nepal became the member of UNO in 1953 and it has taken the non-allignment foreign policy. Today it is the member of different international organizations as well as a regional organizations and institutions.

B Physical Environment :

Nepal lies along the Southern slopes of Himalaya. It is sandwiched between India in the South, and Tibet-region of China in the North. It covers an area of 1,47,181 square kilometers and runs all along 845 kilometres from East to West and 129 to 241 kilometres from North to South. Its shape, therefore, resembles roughly a narrow rectangle.

Nepal may be divided roughly into four natural regions, namely :

- i. Terai,
- ii. The Inner Terai
- iii. Hills and
- iv. Himalayays.

The terai region lies in the extreme south. It comprises a narrow strip of alluvial plain having a very low altitude ranging from only 600 feet to 1,200 feet. The Inner terai is enclosed between the Chure and Mahabharat ranges. It consists of broad longitudinal valleys composed of gravels and alluvia. Both Terai and Inner Terai occupies 21.4 percent area of the country.

Between Himalaya region in the North and the Mahabharat range in the south, lies the most extensive high land called the hilly region. It is rightly described as a "Clusterous succession of mountains varying in elevation from 2,700 feet to 10,000 feet", and occupies 44.2% of the total area of the country. At intervals, this mountain-wall is pierced by gorges of transverse rivers. The Himalaya region which lies parallel to the Hilly region, is nestled on either sides of the Main Himalaya. It rises above the snow-line into the peaks of perpetual snow. Himalaya region which lies at an altitude of 10,000 to 29,000 feet above the sea level occupies 34.4 percent of the total area of the country.³

Nepal receives rainfall mostly from the south-West monsoon. Monsoon starts from the end of May and lingers on until the end of September. The rainfall in the eastern part of the country is supposed to be twice as much as that in the western part. But in winter, the western part of the country receives a larger share of rainfall than the eastern part from the North-East wind which sets on towards the end of December.

The temperature is also not similar in all the places of Nepal, because of great variation in altitude. In the low land of Terai, it ranges from 110° F in Summer to 40° F or even less, in winter. This region has more or less a tropical climate. As one moves towards the rising altitude of the north, cooler conditions prevail. In the Mahabharat range, temperature never exceeds 70° even in summer. But in the valleys enclosed between the various

spurs, it rises even up to 80° F or 90° F at places. In the hilly parts of the country rising as high as 15,000 feet, maximum temperature is around 55° F, while in winter morning temperature approximate to freezing point.

Nepal is highly rich in the river property. It may be divided broadly into three basins drained by three major river systems of the country.

The administrative division of Nepal is heterogenous. Nepal is divided into many local (village) panchayats with different wards in each panchayat. There are totally 4,015 village panchayats (each panchayat has nine wards) and 33 town panchayats (each town panchayat consists with more than nine wards). These total village and town panchayats lie between the whole 75 districts of Nepal. These 75 districts also lie between the 14 zones of Nepal.

C. Resources of Nepal :

The importance of power as one of the prime-movers in the process of development has been recognized so much so that its per capita consumption has been regarded sometimes as one of the indices of economic development.

Coal, oil and gas resources of Nepal have not yet been fully ascertained. Electricity in Nepal was unknown until 1911 when a hydro-power plant was installed at Sundarikal with a capacity of 900 k.w. The supply was increased by 450 kw. when another hydro-power plant was installed at Pharping in 1939. Since then the

hydro-power electric supply of the Government remained constant, until a diesel plant with a capacity of 1,600 KW. was put into operation in 1959. Later on upto the Fifth Five year plan it was increased upto 58,948 KW. of power from new and on - going projects.

Table : 1 Electricity generation by 1978-1988 in Nepal :

YEAR ----	HYDRO -----	DIESEL (IN MWH) -----
1978-79	170319	7176
1982-83	278672	5019
1987-88	563002	1112

Source : Nepal Electricity Authority.

Mineral Resources :

It is popular belief that Nepal is rich in mineral resources.⁴

Forest Resources :

Green forest is essential for ecological balance of the country. It preserves water resources preventing land-slide and soil erosion. The existing fauna and flora of the country has become one of the attraction to the tourists. Medicated herbs available in the forest is one of the component of internal and external trade. It covers about 90 percent of total fuel supply in the country. In the hillregion, it is believed that 50 percent of the animal food is obtained from forest.

Table : 2 Forest of Nepal 1978-88

Total Forest Area	6326500 (Hectare)
1. Hard-wood Forest	53.5 percent
2. Mixed Forest	20.7 percent
3. Conefer Forest	14.09 percent
4. Shrub Forest	10.9 percent
Total	100 percent

Source : Ministry of Forest and soil conservation.

Table : 3 Forest Development Programmes upto mid July 1988.

Item -----	Remarks -----
1. Tree planted area	111038 (Hec.)
2. Community Forest Development Programme	68 (districts)
3. Resettlement +	
a. Resettled Households	87942 (HH)
b. Land Distribution	78110 (Hec)

Source : 1. Ministry of Forests and Soil Conservation
+ 2. Ministry of Housing and Physical Planning.

D. Population Growth 5

It is believed that there is some evidence of partial population counts during the 19th century. But the first population census for which the figures are available was taken only in 1911. Since

then the census was taken roughly every decade. It was not until 1952-54 the census of population was conducted on a comprehensive and scientific basis.

Table : 4 Growth of Population in Nepal : 1911-1981

Year	Population	Growth (+) Decline (-)	Average percentage
1911	56,38,749		
1920	55,73,788	-64,961	- 1.2
1930	55,32,574	-41,214	- 0.8
1941	62,83,649	+7,51,075	+13.5
1952/54	82,56,625	+19,72,976	+31.4
1961	94,12,996	+11,56,371	+14.0
1971	115,55,983	+21,42,987	+22.7
1981	150,22,839	+34,66,856	(+26.6 ?)

Source : Central Bureau of Statistics - 1961, 1971, 1981 and Statistical year book 1989.

About 23.3 percent of population was literate in 1981. 48.7 percent of the total literate population had only primary education (grade 1-5). About 70 percent of the total population was in working age group and 65.1 percent of the total working population was economically active in 1981. Approximately 91.4 percent of the economically active population was engaged in agriculture and allied activities. Proportion of never married females and males aged 10 years above were about 23 and 35 percent respectively in 1981. The proportions of males and

females who were widowed and seperated were negligibly small and the percentage were 0.4 for each sex. 6

Nepal is a Hindu state and of the total population, 89.5 percent followed Hinduism in 1981. Buddhists and Muslim comprised of 5.3 and 2.7 percent respectively. Nepal is a multiracial, ethnic, tribal, non-tribal, caste groups and multi-lingual country. Various linguistic and ethnic groups are knit together by bonds of nationalism and cultural harmony.⁷ While the tropical and sub-tropical regions are largely inhabited by the peoples of Indo-Aryan origin, people of Mongloid features are predominant in the temperate highlands. The national language is Nepali which is understood and spoken throughout the country and it is written Devanagari script. Of the total population, Nepali speakers occupied the prominent position in 1981 by claiming 58.36 percent while other language like Maithili, Bhojpuri, Tharu, Tamang, Newari, Abadhi and others account for 11.1, 7.6, 3.6, 3.5, 3.0, 1.6, and 11.2 percent respectively. Life expectancy at birth for both sexes was 49.53 years and total fertility rate was 6.3 in 1981. 8

E. Transportation and Communication:

Upto the first half of the 20th century, human and animal powers were used as means of transportation and communication. Although Nepal is small in size, from a theoretical transport point of view, it seems to be much more bigger than what it is in reality, because to reach the farthest point of the country takes several days. It is Nepal's topography. that makes internal

transportation and communication both difficult and expensive.

Nepal had only 376 kilometres of road in 1951. This figure has significantly increased to 6306 kilometres of road in 1987, of which 44 percent is the black topped. Of the total kilometres of road, 31 percent falls in the category of highways. In 1951 one kilometre of road had served about 22 thousand of population, but due to the significant increase in kilometres of road in 1987, one kilometre of road had served about 28.8 hundreds of population. One kilometre of road has influenced about 23 square kilometres of land in 1987. 9

F. Agriculture and food

Agriculture plays a crucial role in Nepalese economy in many ways. Agricultural sector accounts at present 92.7 percent of the working population and about one-thirds of the national output. Unless productivity per man of this vast population and per hectare of the scarce cultivated land is increased, incomes of the people can hardly be raised. The vicious circle of low income leading to a low rate of investment and hence, the low levels output and income in consequence is, in essence, the result of low productivity in agriculture at present.

Nepal being pre-dominantly an agricultural country with about 90 percent of the economically active population (1981), more than 42% of the total population, people are below the poverty line. The existing condition of agriculture is far from satisfactory. The agricultural sector is now conspicuous by a low productivity

per man and acre. The low productivity is not, however, due to inherent inferiority of land and labour. It may be attributed to some unfavourable conditions as well as unnecessary pressures on agricultural farm from the government side and local feudals. It is also because, the agricultural products are not satisfactory that the cultivated land in relation to the existing agricultural population is extremely inadequate in Nepal. The first sample census of Agriculture reveals that per capita arable land is only 0.19 hectares. The size of arable land per agricultural family consisting of 5.26 persons measured only 1013 hectare. With the rise in the size of family to 6.13 per capita arable land dropped down to 1.10 hectare. This percapita land is too small to utilize fully the latent potentialities of labour. And the annual growth rate of population in one side is 2.66 percent, but the size of the land is constant. Again this per arable land ratio will be declined. A favourable man-land ratio is severely limited, even in future, by rapid rate of population growth, on the one hand, and the mountainous topography of the country, on the other. The existing situation of overcrowding in agricultural sector has created a state of underutilization or under employment of labour on land will not at all diminish. The contribution of surplus labour to output may not, therefore, be positive. But it is consuming part of the output which otherwise could be utilized in investment works either in land or elsewhere. As land is limited and capital inadequate, the constant growth of labour force on land results only in operation of the law diminishing returns. That is why productivity in agricultural sector is low in Nepal.

The average yield per hectare of Paddy, Wheat, Maize and Millet in 1978/79 was in the order of 1853 kg, 1166 kg; 1835 kg and 1079 kg. The average yield per hectare of the cash crops like sugarcane, oilseeds, tobacco and potato was respectively 16823 kg., 642 kg; 723 kg; and 5499 kg.

G. Industry :

It was the year of 1936 which was the opening of Biratnagar Jute Mill, the first joint stock industrial enterprises in the country. The jute mill was pioneered by some Indian entrepreneurs. Though started on a humble scale with only 150 looms, it worked on profit from the very beginning. Its immediate success inspired confidence of the people in joint stock industrial organization in the country. As a result, five new public limited companies were incorporated in various fields within a couple of years or so. Out of these five, it was only Birgunj Judha Mach Factory, owned and managed by the Nepalese, which turned out to be a profitable proposition.

The industrial structures in 1986/87 is as follows. During the year 1986-87, 9359 establishments (manufacturing industries only) were in operation with 152579 persons engaged. Among them, 61.18 percent establishment belonged to Grain Mill products which neither purchase raw materials nor sell products but provide industrial service to others. This type of industries although comprises of a large number in size its contribution to persons engaged census output and census value added is insignificant.

Table No. : 6 : Number of establishments and persons engaged in

the industries in Nepal during 1964/65 to 1986/87.

Year	Establishments	Engaged persons
-----	-----	-----
1964/65	1260	18701
1972/73	2434	47638
1976/77	3538	50120
1981/82	4903	81050
1986/87	9359	152579

Source : Census & Manufacturing Establishments - 1964/65, 1972/73, 1976/77, 1986/87, CBS, Nepal (relavant portion only)

H. Tourism:

Tourism is also a promising area of industry in Nepal. It is one of the source of foreign exchange earning. It has given increased employment opportunities to the people of Nepal. Gross foreign exchange earnings from tourism was 60229 thousands U.S. dollars in 1987. About 248 thousand of visitors have visited Nepal in 1987.

Table : 7 : Number of tourists in Nepal during 1978-87

Year	No of tourists
1978	1,25,636
1980	1,22,205
1982	1,21,247
1984	1,17,917
1987	2,48,000

Source : Department of Tourism

Thus Nepal is very poor in all its aspects i.e. socio-economic, religious politico-cultural etc. Being rich in resources it is too much poor due to its regulations. People are poor, unhealthy, even malnutrient, suffering from different crises, it is only because of its unequal distribution of available resources.

UNIT II

Health Status in Nepal

A. Brief Introduction

Nepal is a country inhabited by different ethnic, religious group as well as the rich and poor people. This cleavage of the rich and poor ones divides care in sickness quite as sharply as it does any other aspect of the human condition. In this, the division of mankind, the rich have money and medical skills in comparative abundance, the poor have not. So that the poor and rural people have more practice on traditional medicines which determine the nature of the entire practice of medicine in different parts of the country.

Health service is one of the basic needs to the people. So the people have developed both the traditional and modern system of health services to provide health service widely in each and every corner of the country. Not only the Pharmaceutical Productions are necessary but also the trained manpower as well as the knowledge-education to the people for both preventive and curative functions. Knowledge, attitude and practice (KAP) regarding health, diseases, treatment and healthy atmosphere is necessary. So that the production of manpower and enhancement of the planning on health has become an important element in the country. Today teaching and training institute in health of Tribhuvan University has played a significant role in the fulfilling the demand of manpower in the health sector in the country, but it is not sufficient according to the demand of the people in Nepal.

Whatever the institutions (Hospitals, teaching units) are established, all people can not effort the given facilities due to the lack of different means. People are not educated, there are more than 42 percent below the poverty line.

Nepal is still practicing traditional type of treatment like Ayurvedic, Unani, Homeopathic, Naturopathy, raw herbs and others. They also practice spiritual healing, astrology, worshipping, Shamanism, Lamaism, and other super natural feeling and practices. All these are still influencing health services even in the town areas. However, use of modern medicine in many rural places is relatively new phenomena in comparison to the traditional method.

Upto 1950 there were just a couple of hospitals and a very few beds and physicians to treat about 8 million of people (though all the people were not contacting to the doctors/hospital, but the ratio was high). This condition led people to death because of high sufferings from malaria, tuberculosis, small pox, leprosy and malnutrition. Later on, only in 1955 (?) Nepal malaria eradication organisation was established to control the horror of malaria, in 1956 general health planning was promulgated, leprosy and tuberculosis control Projects were started in 1966. It was only 1968, small pox eradication programme was initiated. 10

A document published jointly by Ministry of Health (Nepal) and World Health Organization in 1988 shows that the Department of Health Service (DHS) was established in 1933

but until 1951 the main responsibilities carried out by the department included the promotion, regulation, and management of the following facilities: 33 HMG hospitals, several traditional Ayurvedic dispensaries, an Ayurvedic school, and a production unit for Ayurvedic medicines. Then 1951-55 emphasis was placed on training doctors in other countries.¹¹

Between 1956-61, the first five year plan was implemented. During this period the organization of the Ministry of Health (1956), the organization of Nepal Malaria Eradication, the upgrading and modernization of existing hospitals, the building of maternity hospital was carried out. Priority was given to curative medicine.

During the second three year plan (1962-65) emphasis was given both on preventive and curative medicine for the first time. A survey for smallpox, pilot projects for leprosy and tuberculosis control were launched. The assistant Nursing Midwife training and the Royal drug research laboratory were started in 1964 and by 1965, 102 health posts were in existence.

In the third five year plan (1965-70), more extensive efforts were developed to help plan health strategies for the future. The idea of regular health posts, three vertical projects (small pox, family planning and maternal child health) were introduced. But during the fourth five-year plan (1970-75), Nepal's health priorities changed from emphasizing curative service to focussing more on preventive services. To fulfill

the preventive strategy, IMG established the Institute of Medicine to produce new paramedical workers as well as to train existing medical personnel. In 1970, the community health and Integration division was established to make the health programmes more cost effective.

As part of the fifth-year plan (1975-80), process of integrating the vertical programmes into the overall-health infrastructure was further developed. The catalyst for this activity was the development of a long-term health plan (LTHP-1975-90). As part of this process, in 1975 an elaborate strategy was formulated with participation from not only the Crown but also the National Commission on Population (NCP), the National Planning Commission (NPC), and the Ministry of Finance and Education. The plan called for the expansion of the basic health care services, to rural areas on a gradual basis. The policies of the LTHP included providing basic health services at the village level for the majority of the population and checking population growth to promote national development.

As the sixth five year plan (1980-85) was ideal, so the existing seventh five-year plan (1985-90) focuses on minimum basic health needs of the people according to the UN programme. Primary health care and sanitation were mentioned as two of these needs. The objective of the plan include reducing the infant mortality rate to 98.3 per thousand live births, reducing the total fertility rate to 4.00 and increasing life expectancy to 55.4 years by 1990.

B National Health System-

The national health system which provides institutional services, management infrastructure and service facilities at the national, regional, district and local level on the basis of twelve groups of axioms on medical care and necessity to it the country, Nepalese health system is based mainly on the following basis and axioms:

The medical care of the common man is immensely worth while, medical care must be approached with an objective attitude of mind which is free as far as possible from preconceived notions exported from industrial countries, the maximum return in human welfare must be obtained from the limited money and skill available i.e. in estimating this return means must not be confused with ends and medical care must be adopted to the needs of an intermediate technology. A medical service must be organized to provide for steady growth in both the quantity and the quality of medical care, treat patients as close to their homes as possible in the smallest, cheapest, most humbly staffed and most simply equipped unit that is capable of looking after them adequately, to supply the medical care to all the people all the time, to be organized medical services from the bottom up and not from the top down, developed role playing by the doctor, auxiliaries and medical workers, to adopt own particular methodology and to explore medical care and the local culture which are closely related. 12

The health system at national level consists of the Ministry of Health with its various divisions and units like administrative, manpower, training, policy, monitoring-supervision, Ayurveda, drugs, regional health service, nursing, public health, epidemiology, curative, management development, vertical and FPI, MCH projects, EPT NMEO and several others. At the regional level, directorate of health services have been established and are functioning in five development regions. At the zonal levels, are the zonal hospitals, which serve as referral resources for the district facilities. At the district level, there are district hospitals, district public health Offices. The peripheral level is served by one health post in each Ilaka (areas distributed combining more than two panchayats) in each of the 75 districts, and a variety of field workers.

Organizational Chart of the Health Services in Nepal

Ministry of Health	Health Minister
Division of Health service	Asst. Health Minister
Regional Health Directorate	Secretary
Zonal Hospital	Medical Research Advisory Council and Management Development Section
District Hospital & Health Centre	Additional Secretary (Adm. & Technical - 2)
Health Posts	Departments & Divisions, Sections-sub-sections Regional Director Civil Surgeon (Zonal) Medical Officer (Dist.Hosp.)& Health Assistants Auxilliaries (Health Posts).

There are five types of modern health facilities in Nepal. These are health posts at the bottom, then health centre, district hospital, zonal hospital, central or National hospital and one Teaching Hospital. From the year 1951, His Majesty's Government began establishment of health centres throughout the country in order to meet the basic health needs of the people. Each of these health centres was to be manned by a physician and other appropriate staff. Later on, when this concept was not able to meet its objectives, the long term health plan, established the concept of health posts; managing by paramedical personnel rather than physician. It is the health post which is now the basic unit with lowest level fixed facility of the health system, responsible for providing the basic health services through primary health care to the people of Nepal. By the end of 1988, there were 816 health posts out of which 675 (one for each Ilaka) were integrated. Besides, providing health services through health posts, there were panchayat based health workers delivering family planning and maternal and child health services.

C National Health Plan and Policies

The development policies of Nepal is aimed at a rapid increase in production, increase opportunities for productive employment and at meeting the basic minimum needs of the people. The objective of the seventh plan are to prepare health manpower, provide primary health care to the largest possible number of people through the expansion of primary

health care (PHC) facilities, raise the average life expectancy, expand family planning programme so as to control population growth rate, expand maternity and child health services, and enhance peoples awareness and community participation to alleviate malnutrition.

D Health For all by the Year 2000

Being the member of United Nation's Organization and its major organization i.e. World Health Organization, Nepal has followed different programmes provided by UNO, and WHO in global level. Nepal has a programme as well as the reliable dictum that by the year 2000, the basic minimum need (BMN) will be fulfilled. In the programme of BMN, basic minimum health need (BMHN) is one of them. The BMHN has policies and plans because the development policies of Nepal is aimed at a rapid increase in production, increase opportunities for productive employment and at meeting the basic minimum needs of the people. The objectives of the seventh plan are to prepare health manpower, provide primary health care etc.

To meet the the basic objective of the health for all by the year 2000, the major policies in relation to the implementation of strategies for health for all by the year 2000 are as followed:

1. Basic health services like curative, preventive and promotive will be provided to the rural population through the health posts which are the most peripheral units of the country's health delivery

system. These health posts will be strengthened in order to effectively implement primary health care activities.

- ii. In order to increase the effective coverage of population with primary health care services, ward level volunteers (primary health care workers) programmes will be continued to be implement in all the 75 districts.
- iii. The social organizations under the social services national coordination council, local panchayat and class organizations will be mobilised for primary health care activities so as to avoid duplication of health services and to bring about effectiveness in the primary health care activities.
- iv. The ayurvedic system of medicine will be integrated at the health post and district levels.

In accordance with the decentralization plan, each of the 75 districts is divided into 9 areas called Ilakas, based on population density and geographic area. Each of these Ilakas will have a service centre which will promote intersectoral coordination for community development involving primary school, post office, bank, agriculture, animal husbandry, health post etc. Therefore in each of the 675 Ilakas of the 75 districts an Ilaka health post will be established in

order to provide all components of primary health care services. At the most peripheral level, the ward level volunteers will provide minimum health care to the ward population with emphasis on preventive and promotional aspects.

At the district level, at least one district hospital of 15 to 25 beds will be provided to act as first referral health institution in order to plan, implement, monitor, evaluate and coordinate all the health activities, each of the 75 districts will have a district health office that will work as secretariate of the district health and population committee, which is formed under the decentralization plan.

In order to produce adequate number of trained manpower, the Institute of Medicine, Tribhuvan University will provide the basic training to the paramedical manpower, medical manpower, where as Ministry of Health will provide in-service training to the village level health workers.

In response to provide basic minimum needs, foods, shelter, clothing, health education and security by the year 2000, His Majesty's Government is determined to provide these needs and basic minimum health services through primary health care approach to the rural people from 1987/88 onward in the form of preventive, promotive and curative services, through health posts at Ilaka level and district hospitals.

This package would include awareness and motivation for

healthy living through health and nutrition education, critical interventions like immunization, control of diarrhoeal diseases and acute respiratory infection, provision of safe drinking water and sanitation, adequate supply of essential drugs to all health institutions and family planning services to curtail the undesirable growth of population. Emphasis is placed upon development and expansion of basic health services through the medium of health posts in order to address the urgent needs of simple surgery and preventive measures for the majority of rural population. There are 96 hospitals in the country, but 15 districts still do not have hospitals.

Norms and Projection

Policies and programmes in the field of health have been designed so as to ensure universal primary health services by the year 2000. Priority is given to reduction of annual population growth rate below 2.0 percent. Average life expectancy of Nepalese people is projected to increase to 65 years from the present level of 51 years by 2000. These are expected on the basis of the following:

- a. Infant mortality rate per thousand live birth will be reduced to 45 from the present level of 111.5;
- b. For every 3000 population there will be trained health workers which includes doctors, gazetted kaviraj, health assistant, auxillary health worker, kaviraj, vaidya etc.
- c. For every 600 population, there will be one nurse/ANM and trained staff etc.
- d. There will be one health volunteer for every 500 population on the average.

Programmes

Primary health services has been identified as the basic needs in the field of health because it alone could lead to improvement in health standard of the general population in view of the related environmental, social and economic problems. It relates to appropriate education regarding simple preventive measures, nutrition, safe drinking water, clean environment, and essential drug. The programmes include basic preventive and curative health services, family planning services, epidemic and respiratory diseases related services, nutrition, rehydration services, expanded immunization services, development and expansion of health organization and health manpower.

Working Policies

Following 17 working policies will be adopted in the implementation of primary health service programmes:

- i. Health posts at the level of "Ilakas" in all districts will extend integrated services for effective delivery of primary health services. In an "Ilaka" where there is more than one health post, the rest from the main one will serve as general curative centres;
- ii. Where there is a health post besides the hospital such a health post will be integrated with the hospital;

- iii. Integrated health post will be established in town panchayats without hospital;
- iv. Sub-health posts will be established with people's participation in every panchayat in order to reduce the physical distance between the health service institution and the community at lowest levels of panchayats. Extended health services of the health posts will be provided through these sub-health posts. It will be established on the basis of requests of panchayats and according to standards laid down by His Majesty's Government.
- v. There will be a community Health Volunteers at every ward. They will provide health education and simple curative services related to primary health services;
- vi. District-wise integrated programmes are to be launched in order to extend integrated primary health services through health posts. Provisions are to be made for programmes related to manpower, medicines, equipments and organizational structures for districts with integrated health service programmes;
- vii. District, town and village panchayats will, mobilize local resources besides government resources for necessary medicines and equipments in district hospitals and health posts.
- viii. District hospitals will be established in every

district. Management reforms of hospitals will be undertaken in order to develop health services, along the referral system;

ix. Emphasis is laid upon domestic production essential drugs. Quality and standard of medicines is to be established in accordance with national drug policy;

x. Arrangement for incountry and foreign study and training for district level and Ilaka level doctors and other technical manpower will be made, including improvements in recruitment system;

xi. Preference in recruitment and posting of rural health workers will be given to local health workers with local experience in health projects. Provision will be made for their training for career development;

xii. Ministry of Health will launch programmes in coordination with Ministry of Education for population education and female literacy, Ministry of Agriculture for nutritional food based and available locally, and Ministry of Water Resources and Ministry of Panchayat and Local Development for Clean drinking water and environment.

xiii. Provision will be made for necessary medicines and physical facilities related to drinking water, housing, toilets etc. in the health posts;

- xiv. Establishment of hospitals, health posts and nursing homes in the private sector with own finance will be encouraged according to standards laid down by His Majesty's Government.
- xv. Ayurvedic institutions also will be developed along integrated manner. They will be gradually integrated into health posts and district hospitals;
- xvi. Necessary provision for training for medium and lower level manpower with emphasis on integrated delivery of allopathy and ayurvedic health services at primary health level. There will be extensive general education/training of ayurvedic medicines for rural health workers; and;
- xvii. Coordination and participation of social service national coordination council and related social organizations, local panchayat and class organizations will be promoted in order to reduce duplication of programmes related to primary health services.

Thus the needs of the people has to be fulfilled and His Majesty's Government has made a plan and policies with its strategies to fulfill the basic minimum health need by 2000. But whatever the programmes are made, some of the errors are committed. One of the error is that it has no such programme which will coordinate between different organizations (Governmental, semi-governmental, non-governmental, volunteer, within and outside the country). Also the Projection to reduce the IMR, morbidity rates are unscientific because of

the unequal distribution of medical institutions in the country, lack of nutritional programme or lack of promotive, preventive and curative services. It lacks economic, ethnic, and self medication side, without which the programme of health for all may be difficult to be fulfilled. No integrated programme combining each entities of the society are promulgated.

E Mechanism For Monitoring And Evaluation:

The mechanism for monitoring and evaluation varies according to the levels of the health organization. At the top level Prime Minister chairs four monthly review of the basic needs priority programmes/Projects along with the annual review of all concerned priority programmes/Projects. Likely the Minister of Health chairs the two monthly and four monthly review of the basic needs and other development, Priority Programmes/Projects. The Secretary, Ministry of Health will chaired the two monthly, as well as four monthly review of basic needs priority and other development Programmes/Projects. Ministry of Health takes an active role, being the main means of the distribution of the plans & programme in the health sector. It must plan, organize, staffing, direct, co-ordinate, report, budget and expand the health programme upto the grass root level following the act, rules and regulation of the Government. The division of health collects and analyses the required data which are relevant and what are necessary to be compiled up.

The intermediate level consists of various levels. At the regional level, directive concerning monitoring and evaluation has been issued by the Ministry of Health. However, as the regional health directorates have just been operational, implementation of this directive may take some time.

At the district level, the District Health and Population Committee chaired by a member of the District Panchayat, and including reviews periodically the programmes dealing with health and population activities. It is followed by review in the District panchayat, chaired by the District Panchayat Chairman (an elected member of the district who is a political man, and may be sometimes illiterate). The Local Development Officer (Gazetted Officer chosen by Public Service Commission, minimum graduate or equivalent) is the member secretary of the District panchayat. The membership of the District Health and Population Committee is consisted of the members nominated by District Panchayat-member, president, District Womens' organization-member, president, District Youth organization-member, president, District Ex-Military organization-member, president, District Red Cross Society-member, President, District children organization-member, Chief District Public Health officer-member and District Health Officer member secretary. So it is the combination of all sectors-elected to their associate organizations are nominated. A very few relevant professionals are involved.

The peripheral level which consists of consumers/users committee, under the chairmanship of the Ilaka Pradhan Pancha, reviews the performance of the health post periodically. There is no people's participation in practice.

The indicators for monitoring have been identified and defined and targets specified for the concerned Programmes/Projects of Ministry of Health which includes:

- i. Epidemiological Situation: Infant mortality rate, maternal mortality rate, life expectancy at birth, leading causes of mortality, leading causes of morbidity, incidence of communicable diseases under control programmes and others.
- ii. Demographic Situation: Population size and spatial distribution, Age and Sex structure of the population, population growth rate and others.
- iii. Socio-Economic Situation: Per capita GDP, per capita GNP, Adult literacy rate, water supply and sanitation coverage and the like.
- iv. Health Resources: Health finances, health manpower, health facilities, training institutions, and etc.
- v. Health Services Coverage: Environmental health, health manpower, health facilities; maternal and health child services, immunization, nutrition, malaria, tuberculosis, leprosy, diarrhoeal diseases control, goitre and cretinism, Zoonotic and rabies control, health education, and others.

F Health Delivery System:

There are various ways to deliver health facilities in Nepal. Different health care plans and programmes through governmental, non-governmental, private and international agencies as well as Projects have been launched to fulfill the basic health needs to the people. Among the various programmes, Nepal has the following major system.

- a. Integrated Community Health Care: The integrated public health services started firstly, in Kaski district in 1971 to create additional function for malaria workers, and later in Bara district in 1972 with the aim to centrally manage the public health services being provided by various institutions.

The country health profile, Nepal has mentioned that the integration of public health services has two fundamental policy elements:

- i. integration of all the vertical, single purpose projects under a common administrative structure for each level of health infrastructure, namely village, district, regional and ministerial, and
- ii. Integration of preventive and curative care at the least cost.

Its progress has been slow and was based on experiences gained from pilot projects, experimentation and use of trial and error methods for carrying out policy decisions. During the fourth five year plan period (1970-1975) six districts (Bara, Parva, Kaski, Siraha, Saptari and Rautahat) were being provided with comprehensive rural health services through 62

integrated I type and 289 non-integrated health posts (E type) and district hospitals. The Chief organization responsible for this novel innovation was the integration Board which was founded in 1970 to launch the pilot projects. The Board was chaired by the secretary, Ministry of Health and was supported in its functioning by the Community Health and Integration Division, which was established in 1969 to execute the programme of integrated community health care. An Integration Working Group (IWG) was also constituted in 1971, which body lasted till 1977 the Integration Board and its working group was replaced by a central Integration Board, also chaired by the Secretary, Ministry of Health. The Primary aim of this Board was to coordinate the integration of the vertical projects into the Community Health and Integration Division of the Department of Health Services. In 1980, the Division together with the central Integrated Board dissolved and in their place, the Integrated Community Health Services Development Project (ICHSD) was created under the Development Board Act, 1956.

The integration policy was laid down clearly at the time of the Fifth five year plan. Integration was to be completed by 1985 (i.e. by the end of the Sixth five year plan) which projected the establishment of 1052 fully integrated health posts in all the 75 districts. It also meant the establishment of 15 districts and 4 regional hospital in the same time frame. As envisaged the process of integration was to be gradual in respect of the vertical projects. Due to the various reasons the process of integration was

stopped in 1984. In July 1987, His Majesty's Government decided to integrate all vertical projects activities in the districts and the Public Health Office was given responsibilities of implementing the programme activities. For this purpose district health offices were established in the remaining 27 district without public health offices. To deliver the integrated health services 675 Ilaka (Area) health posts were strengthened. All vertical projects, except Malaria Eradication, Family Planning/Maternity Child Health (FP/MCH) and Expanded Programme Immunization (EPI) will function at the central level till 1990 were dissolved. The functions and responsibilities of ICISDP nonassigned to the Public Health Division in the Ministry of Health. The major functions are family planning; health education; immunization; nutrition monitoring; case finding treatment and holding; treatment of common illness; recording of vital statistics; referral services; construction; training; malaria surveillance; antenatal care; supply logistics; integration of vertical Projects; finance, auditing and budgeting; general management and the this like. 13

b. Nepal Family Planning and Maternal Child Health:

Nepal family planning and maternal child health Project was established in 1968. However, the history of family planning extends as far back as 1959 when a voluntary, non-governmental organization, the Family Planning Association of Nepal, first sought to promote family planning through a strategy oriented towards educating urban-based married

couples by informing them on the availability and use of contraceptives, including social benefits from such usage.

The family planning concept was broadened, when in 1960 it was integrated with the existing maternal and child health programme being carried out by the Department of Health. In so doing, however, a Family Planning and Maternal Child Health Board (FP/MCH) was constituted to execute the Project. Between 1968-77 the FP and MCH Board has undergone several re-organization: firstly, to be headed by the Ministry of Health; then, by a full time chairman and finally by a part-time ex-officio chairman in the form of the Director General, Department of Health. In 1978, the Board was once more reconstituted and renamed the Family Planning Service Board.

Upto 1975, the delivery of (FP/MCH) services followed a static clinic strategy of operations whereby child and maternal health care and sterilisation services were rendered through the 181 clinics covering 64 of the 75 administrative districts in the Kingdom. By 1971, it has adopted the concept of regionalization with the opening of its four Regional Offices in Nepalgunj, Pokhara, Birtamod and Dharan. It was after 1975 that, following the introduction of the concept of Panchayat based Health Workers (PBHW), the service began to be provided more on a door to door basis.

In 1978, a new component to its programme package was introduced when nutrition education was incorporated. Further, since 1980, the priority of family planning method

was shifted from temporary methods to sterilization. In 1977, based on the World Fertility Survey series undertaken in Nepal bench mark data on national fertility and Family Planning indicators were made available for the first time by the Project. In 1980, the National Contraceptive Prevalence survey revealed gap in the demand for the family planning measures of all kinds. In 1984, it entered upon a community health service pilot project to train community leaders on delivery of primary health care. At the policy level, His Majesty's Government adopted in 1983 the national population policy and targets for the year 2000 formulated by National Population Commission.

The major functions are included as child health; maternal health; family planning; manpower development; information-education, communications; planning-research and evaluation and the like.

c. Nepal Malaria Eradication Organization

The Nepal Malaria Eradication Organization (NMEO) was founded in 1958. It was the result of the amalgamation of the Pilot Project, namely (i) Insect borne Disease Control (IBDC) the HMG/USA Project initiated in 1954 with the broad objective of controlling insect-borne diseases in Nepal and (ii) Malaria Control Project the HMG/WHO Project initiated in 1956 which sought to study the feasibility of eradicating malaria in Nepal.

The Nepal Malaria Eradication Organization (NMEO) launched its first operation in the central Region then in 1962 in the Eastern Region; and later in the Western Region of the Kingdom. By 1965 the entire malaria-infested areas were covered. However in 1966 the plan of operation to eradicate malaria in Nepal by 1971 was extended to 1973. Significantly, in 1975, it was conceded by NMEO that it is not possible to eradicate malaria but simply to control it to an acceptable level. The main components of the Plan of operation consisted of spraying and surveillance which, was conceptualized to represent a total of four phases:

- i. preparatory
- ii. attack
- iii. consolidation and
- iv. maintenance.

The maintenance phase was to be executed by the Department of Health as one of its regular budgetary programmes.

The major function of NMEO are spraying; surveillance;

parasitology research; entomology research; health education; training; general administration; and the other related works.

The hopeful and satisfactory achievements in the health field was highly succeeded only in the field of malaria eradication. The morbidity and mortality was very high before 1960 due to the malaria. Its distribution was high in the Terai land so that sufferings were also high in the Terai. Terai was covered firstly to eradicate malarial problems with its prevention programme. It was totally controlled between one and half decades. Not only the Terai but also the hills were affected by this disease. The programme which started by 1950's was highly successful in the 1960's. During this period majority of the people who were suffered from malaria were able to protect their family members. Following this programme, hill to terai migration started, the forest were cleared for agriculture, different petty industries started, various projects and institutions regarding health were established. And today nearly the total malarian habitat has been dried up.

d. Expanded Immunization Programme (EPI)-

Nepal being a landlock country is doing struggle in different fields. Basically, the human protection from various kinds of diseases is not an easy task. Even in the more advanced country's population are suffering from day-to-day new type of diseases as well as minor sickness or illness though people's perception varies from country to country. Nepal,

having a semi-feudal society is not only suffering from financial or poverty crisis but also the usual problems. Malnutrition, handicappism, abnormality, infant death, are very high due to the lack of resources, mobilization of different means of livelihood, trained manpower, education and so many others which are not even upto the minimum level. So to protect the children and other population, programme on expanded immunization plays vital role in the health field.

The Project on expanded immunization programme was founded in 1978. It's predecessor was the highly successful Smallpox Eradication Project which enabled Nepal to eradicate the disease and declared a small pox free zone by the international community. No other project in the health sector, until today, has been able to record a success story of such brilliant significance as the Smallpox Eradication Project.

Public efforts towards the provision of preventive care had started in 1968 when BCG and smallpox vaccines were being provided although not on the mass scale. DPT was begun in 1972. What is new was the conceptualisation of a packages of services for a broader mass target group of children and delivery not only through clinics and hospitals as earlier but on a ward to ward basis backed up by health posts. Further the expansion in the delivery of this total expanded package of immunization was to be gradual. Typically it was implemented first in two terai districts (Dhanusha and

Rupandehi) and one hill district (Sindhupalchowk) in 1978 for feasibility testing and then extended to 6 districts namely, Jhapa, Morang, Sunsari, Mahotari, Nawalparasi and Bhaktapur in 1978 - 79 and 9 districts in 1979/80 (Lalitpur, Chitawan, Sarlahi, Kapilbastu, Dang, Banke, Bardiya, Kailali, and Kanchanpur).

The major functions of EPI are vaccination; training; supervision; logistics and supplies, general management and other planned works.

1. Tuberculosis Control Programme (TBCP)-

Majority of the people have been suffering from the disease Tuberculosis due to various causes (diet, poverty, illiteracy, non-availability of resources etc.). For the prevention from the diseases His Majesty's Government has launched different projects, plan, programme and activities regarding tuberculosis and other diseases. The Tuberculosis Control Programme was established in 1965. Until 1972, the activities of the Project were confined to the Kathmandu Valley. Upto 1966 it consisted of providing BCG vaccination only to those children who showed negative reaction to the Mantoux test. From 1967 a direct campaign of door to door visit to vaccinate all children between 0-14 years of age was started. From 1966 NGOs started to control achievement outside the Kathmandu Valley, most notably, in the Eastern Development Region which was run by the Britain Nepal Medical Trust (BNMT). In fact, during the period 1968/72 it was typical that more vaccinations were done by other Projects than by the TBCP itself.

Extension of the Project's activities to areas out-side Kathmandu valley took place from 1973. As result the predominance of the Project for TB control in Nepal was established, particularly since 1976 when Japan began to assist the TBCP with its service focussing on the Far Western Development Region.

As early as 1973, TBCP had realised the immense task of vaccinating all 0-14 year old within a resonable time frame would be difficult to attain. It undertook an innovation, therefore when it collaborated with the Smallpox Eradication Project (SEP) to integrate its function with SEP by having smallpox vaccinators do BCG vaccinations also. Immense success was reported following pursuance of this strategy.

In 1976, the TBCP enlarged its strategy to include case finding on a door -to-doorbasis. Treatment, however, was to be provided by the Health Post serving the areas. Hence forth, the concept of integration was put into effect.

By 1980, it was anticipated that BCG mass vaccinations would be provided as a matter of routine to all target children throughout the Kingdom by TBCP together with BNMT and JMCT. Between 1980-85 the project launched its new strategy seeking to provide maintenance vaccination. Presently, TB control activities are also done by ICHSDP, United Mission Nepal (UMN), Nepal TB Association and Nepal Red Cross Society. The major function of the TBCP are case finding, treatment, assesment, supply, manpower development and the others.

f. Leprosy Control Programme (LCP)

One of the major problem of human being in Nepal is Leprosy. To solve the problem in leprosy, a project on Leprosy Control Programme was established in 1978. It's predecessor was a joint leprosy-tuberculosis pilot project initiated by WHO in 1965, which was subsequently split for administrative, conceptual and medical reasons. In 1967, the Expanded Leprosy Project took its place. This Project was mainly concentrated in Bagmati and Narayani Zones whereupon it served patients upto a radius of 3 Kilometres from hospitals located in these Zones. One of the chief contributions of the various activities of the Project was the establishment of the Central Leprosy Clinic in 1970.

At the conceptual level, the country health profile Nepal has mentioned, fundamental changes were ushered in, as for example, in the 1963 annulment of an ACE^T which required all patients to be compulsorily confined to leprosaria. Modern care for leprosy victims was begun in Kathmandy in 1958 by the Leprosy Mission International (LMI) when a dispensary was opened at Chapagaun. Then in 1962, the same Mission erected the Anandaban Leprosy Hospital which presently serves as a 100 bed referral hospital with facilities for laboratory testing, reconstructive surgery, nursing, physiotherapy, pharmacy, etc, including training and applied research in epidemiology, dapsone resistance, chemotherapy regimes optimalization, etc. It also serves as a primary health care unit for the local community for obstetric, emergency and in-patient care by way of a 10-bedded ward.

The period 1970-75 is noted for the extension of leprosy control services to 5 more Zones of the Kingdom namely Janakpur, Sagarmatha, Koshi, Mechi and Lumbini. The primary operational strategy for treatment consisted of visits to hospital sites by mobile teams deputed by the central clinic. Following the WHO country Health Programming in 1973/74, and Project Formulation in 1975/76 the aims and activities of LCP were laid down.

The major function of Leprosy Control Programme (LCP) are case holding, education, training, rehabilitation, management and others. But whatever facilities are existed in the Kingdom, it is far to fulfill the basic minimum Leprosy need of the people. Whatever the functions are mentioned they are very slow and the model which they use are far from adequacy and utility. This problem is rising very high in comparison to the facilities provided by the government and other agencies.

g. Community Involvement-

People's participation or community involvement is very important to promote any kinds of programmes. Even to furnish, explore the local or regional or national plans, policies it is necessary to involve people to mention their problems as well as solutions. Community involvement is one of the basic principle of decentralization. Planning and development is the fundamental responsibility of the district and village level panchayats.

To support community and to improve involvement, District Health and Population Committees are established in the district level. Similarly community involvement is strengthened through Health Post Committees and Ward Level Committees.

One positive example of involvement of members of the community is the Community Health Leader (CHL) Programme which mobilizes and trains volunteers as village level cadre of workers to support primary health care. There were 4570 CHLS in 14 districts in 1987/88, who work with their own ward-level Health Communities.

To improve the situation of drug supply at the Health Post level, Revolving Community Drug Cooperative Supply Scheme has been launched in the 32 Health Posts of 12 districts with Who Support.

Ministry of Health has directed that 4-5 Health Posts will be chosen for the implementation of Revolving Community Drug Cooperative Scheme in each of the development regions.

Another example of community involvement is women participation in Water and Sanitation Decade also, the Health Services Coordination Committee is involved in supporting the health, nutrition and sanitation programme at the community level through community involvement in different places.

Like wise one of the Social Service institution i.e. Sewashram Nepal under the community service committee of the

Social Service National Coordination Council, Nepal is providing the health services basically on X-Rays, Laboratory facilities, different health check-up, free service mobile camps etc collecting and gathering different service materials from the people. Volunteers serve in different areas. Experts, technologists, other manpowers like doctors, health assistants are either employed or volunteer. Thus people are participating at the programmes to maintain good health and to get service facilities.

Health Volunteer Programme (HVP)-

Not only the Governmental level is able to facilitate health services to the people upto the grass root level, to promote the health service different programmes are launched. Among the programmes, Health Volunteer Programme is one of them. Community participation plays a vital role in the expansion of health services and their delivery to the people. It will not be possible to improve the health of the people unless they participate in the health programme actively. Therefore the essence of primary health care is the firm organization and full participation of the community and strong support from the government. The community must be made aware of the need for changes necessary for its continuing development. With the realization that successful implementation of any health service programme is predominantly determined by full participation of the people/community. The Ministry of Health has Initiated the Health Volunteer Programme (originally known as community Health Leader Programme) in 1977.

According to this scheme, there will be a HealthVolunteer in each ward of the village panchayat. Job description was prepared for the volunteers. According to this job description the volunteer will provide certain health education and health services in addition to assisting village health workers.

His Majesty's Government has targeted to create and train one Community Health Volunteer (CHV) for every five hundred population as a strategy to promote community participation in achieving health for all by the year 2000. As the basic minimum health need approach has the objective of reducing infant mortality and stresses interventions such as oral rehydration, immunization and child spacing, and as women are directly related to these interventions, the need to promote female health volunteers to promote mobilization and active participation of women population in villages is evident.

About 5600 CHVs have been trained so far in 16 of 75 districts. These CHVs are mostly males with the exception of Baitadi district where selection of female volunteers was made compulsory. Beside, a Mother's Group Programme (MGP) has been in operation in Dhanusha, Mahottari, Dang and Illam since the Fiscal Year 1985/86. While no full-scale evaluation of the Programme has been made, the obvious realities of the MCH situation and general impressions from the programme indicate and underscore the vital role of mothers in the health care of the household.

The new plan for the CHV Programme envisions establishing female CHVs in all districts of the Kingdom by the end of the Fiscal Year 1990/91. In Fiscal year 1988/89 the female CHV Programme be implemented in 27 districts of Central Region and 8 districts of Mid-Western Region. Thus, upto 243 Ilaka Health Posts and 14,337 wards will be covered by the new Programme in the Fiscal Year 1989/90. It was targeted to train 48,000 female health volunteers by the year 1991, so that the health volunteers to population ratio will be 1:500.

A mother's group will be formed in every ward with the joint effort of Nepal Women's Organization Primary Committee (NMOPC) and the VHW working in that Phanchayat. All mothers of the ward, with emphasis on the mothers of infants and young children, will be eligible for membership in the mother's group. However, wards will be free to include young married women (who are yet to be mothers) also in the mother's group. In the process of forming mother's group, the VHW and NMOPC will prepare a list of mothers in the 15 to 45 years age group in every ward and orient the mothers and other related persons including the ward members about the CHV Programme in their respective Panchayats. The CHV will be the member secretary of the mothers group.

Thus the focus of the health programme at the ward level is the female CHV and mother's group, the active male CHVs also will continue to work as CHVs especially in assisting the new female CHVs in activities.

For the coordination with women's organization there is the programme to form a central committee under the chairmanship of Honorable Minister for Health with President of Nepal Women's Organization and other concerned officials as its members for coordination of CHV Programme throughout the Kingdom. Similarly there will have a coordination committee at the district level. The other form will have Health Post Staff to maintain frequent contact with the members of NWOPC, especially with the chairperson and the secretary, during supervision visits to discuss and implement ways to make the CHV activities more effective. The village panchayat level the VHW and the NWOPC will work jointly to form mothers' group to select CHVs, to prepare the list of mothers, etc. So this Health Volunteer Programme is hoped much to supply health service especially in the Primary health care.

i. Drug Scheme-

The Nepalese government (i.e. HMGN) is committed to provide to all the people minimum basic health services through primary health care approach. Until now, a very slow progress is seen but a high degree of slogans and programmes has remained only on as a dictum level. In the delivery of minimum basic health services, among the major constraints is the recurrent shortage of drugs at all health institutions which is most especially felt at the health post- the most peripheral health infrastructure providing basic health care services. It is the experience in Nepal that the annual

consignment of drug supplies for all Government health institutions is sufficient only for about 3-5 months and there is no resource for reordering until the next year's supply is due. For the health post, this annual consignment is worth about 25,000 Nepalese Rupees.

When free medicines at hospitals and health posts run out, the only alternative is for the patients to purchase in private market and the few shops selling drugs are located in town centers only-often more than one day walk away from the village. If the patients could not afford the prices charged, they often remain untreated. Shortage of medicine in health institutions destroys the confidence of the people and undermines the morale of the health staff. Whatever the medicines are supplied to the hospitals and health posts are too much nominal in comparison to the out-patient involvement. In one side the population of below the poverty line is about 42 percent and on the other side the distribution of medicine is nominal so that the poverty suffered population can not afford the expenses on medicine. There is only one Drug formulating agency i.e. Royal Drug Limited, which can not produce as the national need. Importing medicines from other countries costs higher and sometime may not be available.

J. Mobilization and Utilization of Resources-

Nepal is rich in taking benefits from the involvement of a large number of donors (national and international). The resource utilization record provides that almost all programme areas are covered by national programme or by

different organizations, agencies, and/or NGOs. Basically the following areas are especially attracted from external assistance, integrated community health services; family planning/maternal and child health; malaria control programme; leprosy; expanded programme on immunization; nutrition, prevention of blindness, the other elements of primary health care and others.

k. Coordinating with NGOs

Not only the government organizations are successful to promote, prevent, cure as well as to manage the health need activities, but also other organizations, agencies, community people are helpful to promote these areas. So the health policy, planning, monitoring and supervision division in the Ministry of Health acts as the focal point between the Government agencies and non-governmental private organizations. It provides advice and consultation to NGOs on request for formulation of health programmes and participate in meeting and seminars conducted by NGOs at the various levels. The Chief of the Division is an ex-officio member of the Social Service National Coordination Council. Besides, key personnel from different agencies in the Government serve in the committee of the concerned NGOs in voluntary capacity and help in coordinating the activities between NGOs and GOs to fulfill the basic minimum health need to the people. 12

Some Statistical Review on Health Status :

1. Infant Mortality Rate

The infant mortality rate per 1000 live birth was 510 (260 males and 250 females) in 1954 and 247 (136 male 111 female) in 1981 and it was estimated about 106 in 1987. In 1977/78 the rate in urban was 67.2 percent and 105.1 percent in rural with 104.0 percent in total. This rate by topography in 1981, it was were 186 in the Mountain, 163 in the Hill and 122 in the Terai with the average of 144 in total. In 1978, 130, 137, 147, 175 and 165 were in Eastern, Central, Western, Mid-western and Far-Western regions respectively. The infant mortality rate per 1000 live births for major ethnicity in the hill population in 1983 was Newar 153, followed by Brahmin 102, but 120 in Chhetri and highest rate in Tamang which was 300 and the average of 139.

Thus the mortality rate has been reduced since 1954 but this is not satisfactory rate due to the lack of the health facilities, education and other components of primary health care.

2. Expectation of Life

The intercensal (1961 - 81) data shows that the intercensal life expectancies between 1961 - 71 was 36.87 years and 45.31 years in 1971 - 81 period. The estimates expectancy for 1981 was 49.53 years, and 53.02 years in 1988.15 The sex variation is slightly different or the female expectancy is lower than male i.e. 54.38 years for the male and 51.60 years

for the female in 1988. In 1954, it was 27.1 years for male and 28.5 for female but 50.0 for males and 48.1 for female in 1981. Upto 1961 the expectancy rate was higher for female than the male (37.4 Female and 35.2 Male), but gradually it was reduced due to the heavy burden, lack of nutritional diet during pregnancy, or child feeding period and male dominated socio-economic and cultural causes. This life expectancy at birth by area was 51.4, 53.2, 52.4, 53.8 and 50.3 in rural, urban, mountain, hill and terai respectively with the average of 51.9 years as per 1983 census.

3. Crude Birth Rate (CBR)

Due to the lack of education, lack of health facilities, culturally male child expectation, other Socio-Physiological causes has caused high birth rate in Nepal. The crude birth rates for 1000 population between 1952-1987 was not so highly fluctuating, it was 45-50 in 1952-61, 1961-1971 it was 41,44 in 1974-75, it was 42.62 in 1977-78 and 41.56 in 1987. The average CBR in Nepal was 41.56 in 1987. This is one of the major cause for the growth of population (the annual growth rate is 2.66 percent of the total population). The birth rate is higher in the eastern development region (43.64 persons per 1000 population) followed by Western and Mid-Western (40.30 and 40.04), then central (39.60) and the lowest in Far-Western development region (38.59).

4. Crude Death Rate (CDR)

The CDR occurs due to the lack of health facilities, health resources, lack of the knowledge regarding health, lack of

necessary diet during ante natal, natal and post natal period.

The CDR per 1000 population between 1952-1987 varies decade by decade. It was 30.37 between 1952-61, in 1974-75 it was 19.6, and in 1987 it was 14.85. The highest CDR was in Mid-Western region (18.84) followed by Far-Western region (18.10), Western (15.36), central (13.96) and Eastern development region (12.63). The adjusted age specific CDR per 1000 population in 1977/78 has shown the highest CDR in 75 and over of aged (136.8) followed by under 1 years of age (104.0), 65-74 years is 79.6, 55-64 years (36.0) (see for detail CBS, population monograph of Nepal 1987). Altogether in 1977/78 the CDR was 17.1.

5. Maternal Mortaility

The maternal mortality rate was 24 between 1976 and 1978. It was 8.5 per Thousand in 1981.

6. Morbidity and Mortality

Morbidity is due to the various causes which is not yet totally found. But there are 20 major leading causes of morbidity. In 1985/86, the number of people suffered from these twenty major causes were 6009. These causes consisted of mainly normal delivery, obstetric, digestive, abortion, poisoning, tetanus, and typhoid fever. It was 35030 in 1983/84 and 54216 in 1984/85. The mortality rate was 11.75 percent in 1983/84.

7. Fertility Rate (FR)

The fertility rate in Nepal was estimated 6.26 in 1974-75, and 5.8 in 1988. The total fertility rate per 1000 couples by development region in 1987 was 6.31, 5.70, 5.81, 5.77, and 5.55 in eastern, central, western, mid-western and far-western regions respectively. This fertility was due to various socio-economic, cultural, religious-ritual and other causes.

Others

The physical disability in Nepal in 1980 was heterogenous. There were 10.29 percent blind of the total disabled population. Likewise 3.77 percent was visually handicapped, 7.74 percent was one eye blind, 3.90 percent was one eye visually handicapped. The deaf was 9.78 percent, 12.09 percent was hearing handicapped and 11.51 percent was deaf-mute. Likewise the arm defects or disabilities were 11.96 percent.

Thus the health status of the Nepalese people is poor due to the lack of availability of the resources and ill management.

MEDICATION PATTERN IN NEPAL

Nepal is the colourful garden of the different ethnic groups with the ethnic tolerance as well as different life styles with socio-economic, cultural and other life patterns. Altogether about 26 different ethnic groups within Nepal are found. Contrary to all comparable places in the world, there are hardly any areas in Nepal which can be considered to be the area of a certain ethnic group, and on the other hand, there is distinct differences from ethnic group to ethnic group if it is looked at the population as a whole. In single cases sometimes it may be difficult to discover to which group a certain person belongs, and it may seem that differentiation by ethnic groups appears more or less fictional. But looking at the problem more closely and on a larger scale, it will be found that there are clear distinctions and that the people themselves are well aware of these distinctions, the most reliable being clan names.

These ethnic groups have many types of medical institutions and organization which provide the means of medicines and medical services. These are broadly categorised into two major segments.

- i) Modern medicine and
- ii) Traditional medicine and services.

Modern medication includes the hospital and allopathic

drugs through hospitals, drug shops, health posts, either by expert doctors and qualified health professionals or through the drug-shops. But the traditional medication includes traditional form of medicines and its practices like use of herbals, local roots and grasses, believeness on spiritism i.e. exorcism, priesthood, astrological practices. Also the Ayurvedic, traditional Chinese, homeopathic, and other medical practices fall under the traditional medication.

The major factor of the involvment on different medication practices is due to the lack of facilities provided by the government. The hospital and other health insitutions upto 1988 inNepal, were 96 hospitals, 18 health centres, 816 health posts, 155 Ayurvedic units and 4153 hospital beds. The beds in the hospital and health centre were 5083 in Nepal. The distribution of population ratio to hospitals, hospital beds, health post and health centres were 182885.42, 4227.55, 21515.93 and 975398.89 respectively in 1988. So the total facilities population ratio was 18878.49 in 1988 in Nepal (Table: 8 Below)

Table 8

Country	Estimated Population of 1987	No. Hosp. of pop.	No. of Hosp. beds	Health post ratio	H.P. per 100,000 pop.	Health center ratio	Total Facilities	Total Population
NEPAL	1,75,57,000	96	161885.42	4153	4227.55	816	21515.93	18
							975388.69	930

Source: Union, Planning, Monitoring & Supervision Division, Ministry
of Health, 1990.

In one side there is higher rate of population growth and population structure, on the other side there is lower rate of health facilities. In 1983 the percentage of population with per capita income below the poverty line in the rural area was 32.14 minimum subsistence consumption and 37.23 minimum subsistence income which was 20.01 and 10.97 in urban area respectively. This situation shows that people can not afford the health facilities if it is provided in cost-base basis due to their poverty. The gross domestic product distribution to ecological belt was 8, 47 and 45 percent in the mountain, hill, and the terai respectively in 1986. This is also very low in comparison to the poverty population of the country. The per capita gross national product in US dollars in 1979 and 1987 was 130 and 160 respectively. It shows that a person who has only 160 US dollar yearly per capita can not manage his minimum basic needs. The distribution of the health institutions are urban biased and unscientific which can not control the morbidity, mortality and fertility rate.

People who suffered from poverty and can not pay for modern medicine, or the people who have used the modern medicine once prescribed by the experts/doctors, or even who do not use modern medicine, who uses traditional medicine (Ayurveda, herbals, roots, excorciem etc) are due to various causes and problems. One of the factor is literacy rate which was 23.5 percent in 1981. It was only 5.3, 8.9 and 14.3 percent in 1952/54, 1961, and 1971 respectively (see for

detail in HMG/NPC Central Bureau of statistics 1985. Intercensal changes of some key census variables, Nepal, 1952/54-1981). This literacy rate in the urban was 62.0 percent male and 37.5 female where as 32.9 male and 9.8 percent female in the rural areas in 1981. Illiterate people do not understand easily the plans and programmes provided by the government. As for example the traditional people did not accept family planning programme upto the mid period of its commencement due to their view of god blessing to their child birth.

The drinking water available per capita per day was 18513 thousand litres in 1985/86 in Nepal. Only 30 thousand people were facilitated of the available water. Modern sewerage facilities were available only for 5 thousand population in 1985/86. 44.8 percent of the total population is targeted to provide sanitation facilities by 2000. The people who are benefited from the water and sanitation facilities are mostly from urban areas. The rural population is still using the river water which is not safe. Sewerage, toilets, drains etc are not available in the rural areas of Nepal. People are not aware when, where, why and how to use these facilities. It is due to the poverty as well as culture.

The per capita food availability in 1986 was 130.79 kilogram per year which was 0.35 kilogram per day per person and 0.18 kilogram per time. But generally the land labour

uses 0.50 kilogram of food grain at a time. Very few people consume 0.20 kg. of grain a day. It means people are not getting sufficient diet and the nutritional problem is high in Nepal. In Nepal, existing required calorie per adult consumption unit is 3020, 2880 and 2710 in the hill, mountain and terai respectively which averages by 2815 unit but the existing calorie intake per adult is 2570, 2477 and 2660 in the above areas with the 2560 unit average. It means there is lack of resources for calories. This lack is leading people towards malnutritional state and increase of various diseases caused by malnutrition and lack of calorie etc.

The external resources budget in health development programme were implemented in different fields. These budgets were provided to establish and improve the fields of EPI, Nursing, Tuberculosis, Malaria, Health Posts construction, Environmental health, Goitre and Cretinism control, Health Planning, Public health, Integrated rural development, Drug administration, FP/MCH, Health laboratory, Leprosy, Indent procurement/supply, Nutrition, Health education, Medical research, Health, Hospitals, Medical stores, Blindness control, Training centres, Zoonotic control, ARI, Diarrhoeal diseases, CDD and others. UNICEF, Japan, WHO, USAID, UNFPA, NLRA, SATA, ADB, World Bank, IMF, India, Netherland, and other countries and organizations have provided aids for different programmes to improve the health status both in curative as well as preventive fields.

Contemporary Health Care and Services:

The story of the evolution of medicine in Nepal can not be told adequately although different articles are written regarding health care and services. There is contradiction between the views of the scholars about the origin of health care and services. It is a long story stretching from prehistoric to modern times encompassing man through different ages and phases of social development, evolution, culture and civilization. Every culture had developed a system of medicine, and medical history is but one aspect of the history of culture. But one thing is that ancient medicine was the mother of sciences and played a large role in the integration of early cultures.

Primitive Medicine:

Nepal is covered by major rural and hill areas with multi-ethnic groups. The people from the very beginning has been practicing medications through various methods and systems. Out of these, traditional medication systems basically the art of healing was first started. The art of healing began thousands of years ago with the innovations of the primitive man trying to provide relief to those of his kindred in sickness and suffering motivated by feelings of sympathy and kindness. In the absence of an obvious explanation, his limited intelligence attributed disease and other calamities to the wrath of gods, the invasion of the body by evil spirits or the malevolent influence of stars and planets. As a logical sequence, the medicine he practiced

consisted in appeasing gods by prayers, rituals and sacrifices, driving out spirits from human body by noise or violence, and using charms and amulets to protect himself against the influence of evil spirits. There is also evidence that Prehistoric man improvised stone and flint instruments with which he performed circumcisions, amputations and trephining of skulls. It is thus obvious that medicine in the prehistoric era (5000 BC) was intermingled with superstition, religion, magic and witchcraft. 20

The providers of the above medical practices through superstition, religion, magic and witchcraft in Nepal are the Shamans - i.e. Dhami-jhankri, Jharphuke (Exorcists), Lama, Barber, Priests (Brahmin and Lama both), Sudeni (TBA), etc. The methods to provide services by these shamans, traditional healers are separate but the causes of sickness they think as the supernatural power. Sudeni who is one member of traditional birth attendant has separate type of providing means who helps during the time of birth delivery and child care.

The elements of traditional medicine are still practised more or less in all parts of the country. Man still takes to charm, mantras (wisdom by the spiritualists) and other kinds of magical remedies for the cure of illness. There are various types of traditional healers in Nepal who live close to people in the villages and whose treatments are based on various combinations of religion, magic and empiricism. Traditional person may be yet extinct, but the "Supernatural

theory of Disease" in which he believes is not yet extinct in our modern society.

Exorcism which also can be said as Shamanism is highly practiced in the middle hill part of Nepal. In this section Jhankris-Dhamis, Bijuwa and Lama Shamans etc. who use drumset with a twisted stick to throw the evils from the ill body. One of the differentiation between Dhami-Jhankri and Jharphuke is that Jharphuke does not thrill his body, does not use drum and stick, does not heal the whole night unlike the Dhami-Jhankri.

People who are using traditional healer are mostly using Dhami-Jhankri. It is because of their faith, easier to get, more intellectual than the Jharphuke. A study was done in the Chantel of the Dhaulagiri Zone by Wolf D. Michl in describing Shamanism and its utility. It will be relevant to mention his theme here.

Wolf D. Michl in his article Shamanism among the Chantel of the Dhaulagiri Zone shows that one of the smallest groups among the Tibeto Burman speaking populations of Nepal are the Chantel (approx 5000). 21 Their outstanding characteristics lies in their former occupation, they were exclusively engaged in copper mining. Wolf tried to investigate the inter-ethnic relations between Chantel, Thakali and other Magar Sub-tribes of that region, including the impact of Hinduism on these ethnic groups, but soon he came to realize that Chantel were a group apart, that many of the Thakalis

had left that region because the copper mining stopped in 1930-31 and trade with the Chantel was no longer profitable; there were almost no inter ethnic relations between the Chantel and the surrounding castes and ethnic groups.

In the Chantel group, they claimed to be Hindus but it is obvious that they were much less influenced by Hinduism than their nearest neighbours. The Chantel pretend to employ Brahmins for every important life cycle ceremony such as birth, marriage and death, but sometimes they neglect them due to the Brahmanic performed Sanskritic rites in the village. Only a few Chantel own a Jamma Patra (astrological birth certificate).

The Jhankri (Exorcist) is the most important religious expert among the Chantel. In Ath Hajar Parbat (named as eight thousand foothills) there were four of them including one Jharini (women shaman); the Kami-Jhankris were more numerous but it is difficult to give the exact number because as the researcher was told by the Chantel every Kami is potential Jhankri and communicates with ghosts and spirits anyhow.

The Jhankri has a Guru (expert guide or god/goddess) who is identical with the tutelary deity and they deny any initiation by a human being. The Guru can be called at anytime, no special offering or preparation is necessary. At the very moment when the Guru enters the Jhankri's body his head begins to shake and body trembles. The Guru protects the Jhankri against Witches (boksi, daini) and other evil spirits

such as bhut (ghost), rakhas (dragon) etc. In return the Guru expects strict obedience, and if the Jhankri does not obey he will be punished severely. The Jhankri will offer dhupa (fire and butter or dust from tree-flower or leaves etc) to his Guru from time to time but at the beginning of a seance this offering is compulsory.

At the end of the seance when the Jhankri has found out the cause of the trouble through his contact with the supernatural world he tells the client which measures are necessary to appease the angry gods or to kill or drive away the evil spirits.

The Jhankri of Ath Hajar Parbat is also a religious policy maker. As a result of his pronouncements, particular deities appear, gain prominence, lose prominence and disappear in the village pantheon. 22

John Hitchcock writes that the approach to Nepal as a diffusionary cultural interface has had a long history and during the late 18th and early 19th centuries is associated with the names of British officials such as Kirkpatrick, Hamilton and Hodgson. Barreman has noted that some people of the Nepal Himalayan do share many cultural traits with Tibetans and others have been thoroughly Hinduized. Thus the practice of self-medication depends upon their cultural practices which is shared with whom/which will borrow the practice of medication because self-medication is also influenced by the culture of the people.

A weakness in this perspective in the opinion of John Hitchcock, is its omission of other traditions, including the one where he was concerned within the essay, a form of Shamanism which may be termed Dhaulagiri Shamanism, because it flourishes on the southern and western slopes of the Dhaulagiri range. If one is mainly interested in Nepal, and particular in this region, as an inter weaving of Indian and Tibetan cultural strands, much of this religious phenomenon simply fails to register. It is of interest from the Indianists' point of view that the first (and mythical) Shaman is called Rama, and from the Tibetanists, that contemporary Shamans in their chants invoke powerful Lamas. But from a different perspective these and many other diffusionary features are peripheral and relatively insignificant.

One moves easily from a conception of Dhaulagiri shamanism as a reflection of two civilizations to an approach associated with Red field and his followers. 24 From this perspective one's focus is on textual materials deriving from the Tibetan and Indian cultural traditions, and the questions asked have to do with whether or not the complex reflects ideas of the great Tradition and is a vehicle through which these ideas operate in the lives of ordinary people. Or one might ask whether some of its ideas have been received into either Great Tradition, there to be reworked and preserved in the writings of the learned.

John Hitchcock findings show that Dhaulagiri Shamanism is shared by a number of ethnic groups. But the shaman is a recognized status filled by men who are self-selected, usually on the basis of a supernormal experiences. They serve an apprenticeship to a practising shaman, learning spells, rituals and a long song cycle. Some of the help a shaman provides a client is neutral with respect to the community. His spells, rituals and songs are directed against supernatural beings. However, when a client is being bothered by an enemy, an opponent in a court case, for example, and often happens, the shaman provides assistance, his powers are directed at individuals within the community. What is good from his clients' point of view is bad from theirs. With respect to good and evil therefore the shaman's status is ambiguously coloured.

Shaman is consulted in many rituals and dramatic expressions, but probably none is more central and explicit than the act of possession itself. During a seance the shaman plays host with his own body to spirits whose evil potential is known and feared. Thus although he is helper and champion of his client, he has become at the same time dangerous and an embodiment of evil. The song which they used is one of a number that accompany various rituals during a seance. Of all the songs, it is the most frequently sung, partly because it legitimizes the shaman's transcendental persons, but also because it is used to rid the client of witch-evil, a most common source of human ills. They have typical type of

history saying while organized a thrilling function to be spelled out the wisdom. Firstly the study tells of happenings in the First Age of the World's present era. Nine witch sister, the gift of god to an aging childless couple, have grown up and have begun to do evil. This history shows the alliance and the spiritual belief and life pattern of the area or group or community. This helps to maintain their health status according to their practices.

So Dharmi-Jhankri (Shamans) who have a higher prestige in Nepal play a significant role in the health care. They are not the negligible agent but the helper and volunteer in the health field. They invoke both malvolent and benevolent spirit in ritualistic process.

Priests: Priests are those who have two kinds. One is the pandit (scholar) who have right to speak, lecture at the programme of purana (an organized seven to nine days lectures regarding religion) who must have minimum Madhayama (Intermediate degree in the Sanskrit education) and the other is Purohit or Pujari who do not hold degree but knows to pray, worship or can organize a worship as the people demand and want. They pray for the cure of the sick clients. Also they hold a higher status. They do both: use horoscope along with astrological works and praying to god to throw the evil caused by the planet and evil spirits, gods penalties etc. This is one of the great factor which upgrades health status though it has tremendous demerits.

Herbalist:- is another category of faith healing practices considered as traditional medication pattern. This is helpful more than the shamanism and exorcism. Herbalists are those who collect roots, leaves, grasses, barks, fruits and the like which used to be provided to the patients who are in contact of them. They hold a great prestige and frequently named as the "doctor" in their local areas. The practices of the herbalists are not seen through a fixed shop but the medicines used to be kept in a Kit-box or covered by a cloth, or used to take immediately from very near places. But sometimes the herbalists used to sell their traditional medicines from their stall. These medicines are made according to their uses. Sometimes they are grinded, sometimes pieces, or whole, cooked, half-cooked, totally raw or ripe, dry or green and the like.

Besides the above the other traditional medication pattern is based upon the consultation with the vaidhyas which has two types. One of them is apprentice by parents who does not hold a formal degree but the other holds formal degree and practices Ayurvedic medicines. Even though they use stethoscope, check blood pressure, use thermometer, just the same system of the modern allopathic medical practices but the medicine differs. The same medicine is used as used by the herbalists but in a well reformed way. This Ayurvedic system has strong socio-culture base with formal and apprenticeship education systems derived from historical, empirical and scientific experiences, theories and practices.

This system has recognisable base and infrastructure supported by the Nepalese government. This system is being integrated into primary health care at the health post level. Not only the health post is providing the Ayurvedic medical services but also the Ayurvedic drug sellers.

Drug salers fall under two types. One is trained and another is untrained. Trained are those who have formal education and training, the other is untrained who do not have degree or training but have experiences for selling medicine. Drug salers often prescribe medicines to the customer. Self medication is practised from the drug shops both by saler and the customer.

Quacks are those who do not hold degree in modern medicine but has a little knowledge regarding modern medication who provide service from outside their jurisdiction. They hold a training of limited period of time sometime and sometimes they have no such trainings but practise with their experiences. Sometimes they are called as injection doctor, even doctor or any local names.

Homeopathic system is also in existence in Nepal. This system has two kinds or products. One who has got formal education and training or holds an academic degree from recognized institution and have equal right and status as of the modern allopathic experts and doctors. The other are those who do not have formal degree but have a little knowledge and experiences. Homeopathic medicines are not

different than the Ayurveda but the implication system is not similar. Ayurveda diagnoses the causes of illness, sickness and diseases first and prescribes later but homeopath applies medicine first than diagnose the causes by its reaction. This is not so highly renowned as the Ayurvedic system but has its great significance.

Greek medicine in Nepal has earned the reputation and taught people to think in terms of 'why' and 'how'. It is consistent with environment health such as climate, water supply, clothing, nutrition, habits of eating and drinking and the effect they have in producing disease. This is associated with the diseases caused by natural process, not a visitation from a god of immolation. They have scientific method although not scientific knowledge.

Besides the above there is another type of medical system which is known as Chinese medicine. It claims to be the world's first organized body of medical knowledge. It is based on two principles - the YANG and The YIN. The Yang is believed to be an active masculine principle, and the Yin a negative feminine principle. The balance of these opposing forces meant good health. People have more believes and practices of this system in Nepal. It is also similar with the Tibetan medicine. The persons who provide services in this field are the product of formal training or education in accupuncture or Chinese medicine as a whole. Sometimes, people with experiences do serve this medical practice.

The other service providers are Traditional Dhai (TBA) and relatives. They do their services in the villages for FP/MCH and delivery, the postnatal mothers and child care. They even serve the critical cases without authority and if bitter accident is arose, no penalty will be given either by the government or by the people. They also have a good status in the community. Their job description is not yet published but have only limited areas mentioned in certain literatures.

Barber whose main occupation is to make, cut the hair but often does nail cutting, oiling, abscess draining and care of small injuries.

Compounders who have very short period of training on primary care of certain injuries, accidents etc hold a prestige like a expert within the community due to their regular services. They also practice even outside their jurisdiction for financial earning, and social prestige.

Some of the Sunuwars and Kamis help people in dental care by attaching the gold and iron on teeth after cleaning the teeth.

There are also other practices like cupping on the external body, on the wound, etc. Sometimes they use mouth to wound or painful areas. Massage using some oils or drop is also practised in various areas of Nepal. In snake bite stones, dusts and chicken is used to protect from the poison.

Self-medication practices is more in Nepal due to the following causes :

1. Lack of modern medical experts/doctors in comparison to the population.
2. Lack of health institution.
3. Lack of different resources.
4. Lack of planning and policies formulated by the organizations.
5. Lack of health education to the people.
6. Lack of economic opportunities.
7. Lack of subsisting means of economy along with the subsidiary means to manage and fulfill the daily basic needs.
8. Unavailability of medicines and if available high cost which is not tolerable to the people due to their povertyness.
9. Availability of the traditional providers which is lower cost, easy to meet, culturally attached.
10. Traditional medication are tolerable due to the types of society, other socio-economic, cultural settings, development and the others.

UNIT - IV

Objectives:

It was mentioned that more than 50 percent of health problems never reach the health services. They are treated through a system of self-care or self medication which may be based on home remedies, commercial sales of traditional and modern medicines in Over-the Counter Sale (OTC) often combined with religious feeling practices.

There are various studies done in the field of self-medication which make reference to the cultural and behavioural aspects of self medication, more studies appear to have been done in the United States of America or Europe or in Africa than in Asia. Among these the studies have looked at :

- a. Self-medication - selfcare as to utilization pattern, costs patterns of referral.
- b. Kinds of drugs used and geographic distribution.
- c. Socio-economic factors affecting self-medication.
- d. The medicalization of social life through self-medication, and,
- e. Study of injectionists and "quacks" as to uses of drugs.

While there seemed to be a wide range of investigations, infact, most of the research had been conducted in the context of interest. Also, much more attention had been paid to the patients/consumers side than to the providers. Few looked specially at the socio-cultural aspects of Essential Drugs Programmes involving consumers and provider at the community level. Consequently, most of the information available does not allow one to make conclusions concerning the entire system of drug supply, distribution and consumption pattern which could be applied to policy-making. The project is conducted thinking that there has been no comprehensive Asian study which investigates the socio-cultural aspects of self-medication, its health impact, linkages to the Essential Drugs Programme, and the operation pattern at the local level.

Some of the studies at different rural areal of Nepal show that only between 16 to 20 percent health care are provided through governmental health institutions. The rest are still taken care by self treatment, locally available traditional health care system or without any treatment. The role of the traditional health care system is providing primary health care services in important and unavoidable. The traditional health care system in Nepal also plays a vital role in the health service which is described under III. In addition, many families have a system of home remedies and self treatment. Often a household would possess a 'drug bag' containing animal and plant products, stones or

some chemicals, soil etc which is believed to have some pharmaceutical properties. In some households such bags would include items of modern medicine like analgesics, antacids, antispasmodics, sedatives, antibacterials and other simple medicines.

Essential Drugs Scheme and Drug Administration Activities in Nepal

Nepalese government has a national drug regulation concerning manufacturing, storage, sales and distribution of drugs. Although there is regulation for distribution of drugs from outside Nepal, there is no definite control and statistics on sales of such drugs, which may include antidiarrhoeal, vitamins, anabolic agents, hormones and antibiotics. This has immense social and biological hazards related to the misuse of drugs. A pragmatic enforcement approach is necessary to curb the misuse of drugs and one which respects the harmless or beneficial aspects of self medication. The socio-cultural aspect of medications involving both consumer and providers are important parameters for understanding therapeutic and biological aspects of medication, but they are largely overlooked. So this programme is set forth to explore the medication pattern on the socio-cultural background. The socio-cultural study of self-medication has tried to answer with evidences the part of the problems.

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This study has intended to look into :

- a. The various methods of self care system in Makwanpur district,
- b. Their types of therapy used,
- c. Their socio-cultural aspects of drug use,
- d. Their existing knowledge, attitude and practice about the drug use for self-medication,
- e. The referral system,
- f. Education, innovation, adoption and internalization of self care system for primary health care.

2. Justification:

The practice of self-medication is so widespread in Nepal that it probable be impractical to aim at doing away with it. However, it was necessary to conduct research on the problem of self-medication in order to :

- a. study the use of beneficial and harmless medications in the self-care,
- b. explore the possibility of internalizing modern medication like ORT, nutritional - supplements and weaning diets, family planning methods, immunization, basic sanitation and personal hygiene, first aid, aseptic care of wounds and cuts, health education etc. into the self-care system,
- c. generate the system to discourage inappropriate and harmful drugs and methods in the self-care,

- d. study the options for community participation and community supervision in self-care system,
- e. discourage the use of unnecessary drugs and over use of drugs including vitamins.

Finally, this research has tried to seek the means to use self medication to strengthen primary health care in Nepalese villages, educate providers and consumers to minimize misuse of drugs and to promote health of the community.

3. General Objective:

The general objective was made to investigate the socio-cultural aspects of self-medication and its uses and abuses, its adoption and innovation to complement primary health care and to evaluate its impact on community health.

4. Specific Objective:

Under the general objectives, the specific objectives were set up to :

- a. gather baseline data of demographic, socio-cultural and epidemiological characteristics of the selected community practicing self-medication.
- b. evaluate knowledge, attitude and practice of both consumers and providers in relation to :
 - 1) types and nature of self-medication by geographic and ethnic distribution including rural and urban.

But the research was conducted to see the types and nature of self-medication excluding geographic distribution because of the heterogeneous settlement of different ethnic group in different areas. The places were chosen by the heavy distribution of the population with multi-ethnic group in the urban or the terai-half-urban and rural cum half developed hill area. Places were Padam Pokhari village panchayat in the Terai and Makawanpur Gadi panchayat of the hill area or Makawanpur district,

ii) Methods of collection (see methodology), processing, preparation and use of local medicines (see chapter V),

iii) Conditions forbidding their use,

iv) Belief on their effects and side effects,

v) Ritualistic taboos associated with the self-medication

c. explore the opportunity for education on inappropriate and unnecessary self-medication.

5. General Research Design:

5.1 Makawanpur district was chosen for the purpose of the study because of this district has multi-ethnic groups with diversified socio-cultural practices with both urban and rural distribution of villages.

5.2 This research was divided into two phases. First phase was scheduled for 10 months. Within these ten months preparatory phase was for two months including the mapping of Makawanpur district for the research, contacting village leaders (Pradhan Pancha, Upa-Pradhan Pancha, ward members, community leaders, elderly persons, shamans, drug shopkeepers, priests, vaidhyas etc), and rapport establishment. This period also included general descriptive accounts for study and also the preparation of test instruments, focus group interview and qualitative methodology. This was followed by pretest and initial field tabulation for a period of one month. Pretest's result was sound and useful so the programme of research was implemented for three months. The development of research design was essentially been field activity. The two research assistants were given training before going to field. After the implementation, the data collected from the field was processed and analysed in one month duration. Intensive cases and problem study was done after analyzing the data but some of the case studies were also done during the field study.

6. Methodology:

6.1 Sampling:

All the village panchayats of Makawanpur district was enumerated for the sample. Two village panchayat namely Padam Pokhari in the Terai, which has urban as well as

rural areas with multi-ethnic groups, and Makawanpur Gadl village panchayat in the hill having urban and rural and multi-ethnic group has been chosen on the basis of the heavy population concentration of the district for the indepth case study on self medication. Each of the selected panchayat was mapped with ethnic details, but was not possible to be sampled geographically due to the heterogenous settlement of the various ethnic groups in each area. Finally random, stratified, proporionate sampling using random number table was drawn from the ten percent of the households, ten percent of the population and ten percent of each ethnic groups in each panchayat.

6.2 Test-instruments and methods (with pre-test phase):

- a. In-depth open-ended questionnaire were used for each sample household after pre-test. Also interview with the traditional healers, drug-sellers, community leaders and the community members was done.
- b. Questionnaire interview of the sampled households, group interviews including all the members of the family were taken.
- c. Observation of the "drug bag" used by the households including ritual processes for the self-care and narrative descriptions of self-care processes was done at the field during the interview period.

- d. The narrative study and intensive study of a selected number of cases undergoing self-care treatment and problems related to these were conducted. These studies covered chronic sufferers, acute sufferers, traditional providers, users, modern drug providers, its users, and the general people.

The base line survey of the sampled households and family members was conducted to know the socio-economic and cultural, demographic and epidemiological characteristics, which was related to the self-care. In addition, it was tried to evaluate the knowledge, attitude and practices of providers and consumers regarding drugs. The study classified the self care patterns in the communities, and also recorded the benefits, changes and side effects of the self-medication, studied the historical and socio-cultural link and effects on sickness and health of people related to self-care. With the help of local leaders and records of the panchayats, an inventory of the local providers were enlisted.

The personnels involved in this study were two principal investigators, two consultant advisors, two short term consultants (health education, statistics), one field supervisor and two research assistants.

Principal investigators, consultant advisors & also short term consultants and supervisor hold responsibilities

for the development of the research design, test instruments, planning, implementation, evaluation and final write-ups. Also principal investigators, and short term consultants, trained supervisor and research assistants, and supervised the field work.

UNIT - V

FINDINGS AND EVALUATIONS:

The preceding chapters provide the overall brief picture of different disciplines. This chapter deals especially with three grounds:

1. The first deals with general population with age, sex and ethnicity along with the sick population, socio-economic, cultural and religious structure and practices in Padam Pokhari, Makawanpur Gadi and both panchayats with some of the statistical explanation with comparison to national, regional and local levels.
2. The second sector consists of sick population and self-medicated population, their age and sex and ethnicity, consulting agencies or means and their KAP regarding health problems.
3. The third and last section provides general picture of the providers, both modern and traditional, their use, their KAP, and other associated of the providers.

So this chapter consists of demography, variables and details of consumers and providers. Makawanpur Gadi panchayat is given abbreviation as MGP or M. Gadi, Padama Pokhari panchayat is abbreviated by PPP and the total of both panchayat is as MP cluster.

General Introduction to Makawanpur District:

In central Nepal, there is Narayani Zone having five districts namely Makawanpur, Rautahat, Bara, Parsa and Chitwan. Geographically Makawanpur district has both hill and Terai lands. Daman, Palung and Tistung in district get snow falls. This district is surrounded by other districts. This district is situated in the north of Bara and Parsa, in the east of Chitwan and Gorkha, in the south of Lalitpur district.

The district is also covered by the forest. The forest in the terai region of the district is dense and timber export provides a high rate of revenue collection. It is helpful to fulfill the fuel crisis but the heavy deforestation, clarification and confiscation of forest is bringing desertification in this district.

There are several natural resources like water resources, forest resources, herbal resources, mine and mineral resources, raw material resources for industries, transport and communication, establishment of industrial sector, other developmental institutions and health institutions.

Makawanpur district is a historic place. Late king Prithivi Narayan Shah, a founder of Nepal, who unified this country, had marital relations with the 'Sen' dynasty of the Makawanpur Gadi. He had first marriage with the daughter of 'Sen' who was the ruler of that area then. Later on when Rana

regime existed in Nepal this district was the only way to pass to other areas from the Kathmandu Valley.

People with more than 26 ethnic groups are settled in this district. But major concentration is of the Tamang group. The population in this district is also higher than the other areas of Nepal except modernized urban areas (Kathmandu Valley, Biratnagar etc). The population by ecological zone and development regions show that the central development regional hill population was 14.03 percent in 1971-1981 which was 15.07 percent in 1961-1971 an annual growth rate between 1971 - 1981 by 1.91 percent. The central developmental regional Terai population was 15.89 percent in 1981 and 15.32 percent in 1971 with an annual growth rate of 2.99 percent.

The population and density per square kilometre in Makawanpur district in 1981 was 2,43,411 persons, 1,25,480 male (51.55 percent) and 1,17,932 female (48.45 percent). It's area was 2426 square kilometre and density per square kilometre was 100.3 persons.

The average household population in 1981 was 6 Persons in Makawanpur district, and 40,568 households with 69.3 percent economically active population. The linguist groups were 44.2 percent Tamang, 41.9 percent Nepali, 8.9 percent Newari, 4 percent Praja, 0.3 percent Magar and 0.7 percent others. People who had labouring profession were 95 percent tenants including landlord, 2 percent wage labourer, 2

percent businessman and 1 percent industrialist in 1981. The major land was tilled for maize cultivation with an area of 17417 hectare and the maize production was 22,120 metric tons with 1.27 percent per hectare metric tons. It was followed by paddy production then wheat, millet, potato, sugarcane and tobacco. There were other cash crops and fruit production like banana, guava, mango, local apple, etc. Like wise the vegetables were green leafs, cauli flower, spods etc. The supportive and subsidiary means of economy in this district was animal husbandry. Cows, bufallows, sheep, goats, pigs, chickens, ducks and other pet animals were pet for both purpose to sell and earn cash or to eat. There were 5,76,267 all types of pet animals in 1981 in this district. Milk products, meat, eggs and woolens were produced for cash earning and local use. There were about 13 vateniry service centres in the thirteen places of the district with 13 technical and 13 non-technical personnels. The fishery development was established here. The fertilizers for the agricultural production used were aluminium sulphate, urea, complex, TSP, Potash, lime etc. The insecticides and tools for the protection in the agricultural products was 16,100 litre. liquid, 2,316 kg. of dust and 31,559 agricultural modern tools. There are Hats and bazars (local markets) to sell and buy the materials which are organised either weekly or daily depending upon the alitude, development, need of the area and people. The co-Operative offices were 14 in this district in 1981, which was effective to provide loans on different programmes to the people, management of materials,

and others. Banking service was started in 1836 A.D. in Nepal and there were 6 Nepal Bank Limited (Semi-Governmental), 3 Commercial Banks (Governmental), 4 Agricultural Development Banks (Governmental), and 11 small farmers development programme under agricultural development banks in the district in 1981. There were 41 irrigation canal (Kulo) which were effective to irrigate about 4,100 hectare of lands. The drinking water facilities were provided in the public sector by 1952 tap water line to 25,000 population of the 1947 family members (households) where the distribution was averaged by 30,00,000 litres. From the district panchayat development aids, there were 246 drinking water programmes implemented. The forest resource was available in the area of 1,52,239.68 hectare of land which covered about 62 percent of the total lands. Panchayat Ban was extended in 1970 hectare of land and panchayat protected Ban (forest) in 11.73 hectare, private forest (Ban) in 5.25 hectares. There are three major medicinal plants development gardens in Brindaban, Daman and Tistung.

There is a district hospital with 25 beds and 12 health posts in the district. Zonal Ayurvedic dispensary also provides health services in this district.

There is also a district public health office to promote the health status in the district. There is a programme in the district to have 1 health assistant for 3,000 population, one nurse for 600 persons, one health volunteer for 500 by

the year 2000 A. D. making a total of 125 doctors, 625 nurses and 750 health volunteers.

This district has 43 village panchayats each having 9 wards, one town panchayat with 11 wards. Each village panchayat has 11 political leaders (9 ward chiefs and one chair person and one vice chair person). But town panchayat has 13 political leaders (11 ward chiefs and one chief of the panchayat, one is vice-chair person). There are 6 class organizations and one district panchayat. District panchayat has 11 members (one president and one vice-president).

There are about 18 religious totems of Hindus, Buddhist, Muslims and Others. Tourism is also effective due to the historical places. Tourists from the overseas and neighbouring countries used to visit mainly in the 6 places of the district.

Population and households by sex and ethnicity in the sampled area (Makawanpur Gadi, Padam Pokhari and Both)

The district panchayat records showed there were 1370 households in the Makawanpur Gadi Panchayat (MGP) and 1800 in Padam Pokhari Panchayat (PPP) making a total of 3170 households with 8860, 11640 population in MGP and PPP respectively. The ten percent of total households in both panchayats were taken into sample i. e. 138 and 181 in MGP and PPP using random number table. Out of 319 households, the highest number of households belong to Tamang family (57.4 percent of the total sampled households) followed by 27.3

percent Brahmin and Chhetri (Tagadhari or twice born caste group), 5.9 percent Magar and Gurung, 4.4 percent Newar and 5.0 percent untouchables (i.e. Kami, Damai) and others caste group (Rai, Giris etc) (Table : 1.1 A, 1.1 B). They were concentrated there due to various socio-cultural and economic reasons. Some of the reasons given were their relatives, kin members and availability of means of economy, labour opportunity, resources, educational institution, traditional healers, a health post and hospital facilities as well as closeness to Kathmandu valley to sell and buy commodities. So the settlement even after migration was easier because of the interaction with their ethno-relatives. The other cause given was free land distribution to the Praja group by the government under settlement programme. They used to sell these land and would buy the cheaper one in the PPP, thus saving some money.

The second major concentrated group was Brahman in the cluster having 46 households in the MGP and 19 in PPP with the total of 65 in the MP cluster. The total Chhetries households were only 22 in the MP cluster. The total of Brahmin and Chhetri households was 27.3 percent (see table 1.1 B and pie-chart). The causes of the concentration of these caste was same as Tamang. Besides they were benefited from animal husbandry by selling milk to the local dairy and other business.

The third major group was Magar having 14 households

followed by Newar and Kami (each 14 households), Gurung (5), Damai and Rai (each 1) in the MP cluster. (Table : 1.1 A)

The table 1.1 A shows the population by sex and ethnicity, and sick population in the MP cluster, MGP and PPP. In the 319 households there were 2050 total population distributed as 1026 males and 1024 females. The total population in MGP was 886 (437 male and 449 female) and it was 1164 in PPP (589 male and 575 female). The total sick population (two weeks of illness) was 157 in the MP cluster (78 in the MGP, 79 in the PPP) which was 7.7 percent of the total population.

The types of family in the MP cluster were 116 extended, 200 nuclear and 3 joint family which constituted 36.4 percent extended, 62.7 percent nuclear and only 0.9 percent joint family. The average family size in the MP cluster was 6.4 persons. So, there were more nuclear family separated from the joint and extended family due to economic, marital and conflict between the members of the households.

The distribution of sick population was as follows. Tamangs 51.0 percent of the total sick population, followed by Brahmin 26.1 percent, Chhetri 10.9 percent, Kami 3.8 percent, Magar 3.1 percent, Newar 2.5 percent, Gurung and Rai (others) each 0.6 percent.

Table : 1.1 a

Sampled household and population by ethnicity and sex in
Makawanpur Gadi Panchayat, Padam Pokhari
and Both Panchayat

Ethnic Group	Population												Family type														
	Household			Makawanpur Gadi					Padam Pokhari				Total of both WP				Extended			Nuclear			Joint				
	MG	PP	Total	M	F	Total	%	pop.	M	F	Total	%	pop.	M	F	Total	%	pop.	MG	PP	Total	MG	PP	Total	MG	PP	Total
						pop					pop					pop											
Brahmin	48	19	65	174	177	351	39.57	34	55	61	116	9.97	7	229	238	467	22.78	41	24	13	39	22	6	35	-	-	-
Chhetry	15	8	22	51	58	109	12.29	12	22	18	40	3.44	5	73	78	143	7.27	17	5	3	8	11	3	14	-	-	-
Magar	8	8	14	18	19	37	4.28	3	21	21	42	3.69	2	39	40	79	3.86	5	5	7	6	1	1	8	-	-	-
Kwar	14	10	14	18	16	32	3.61	2	37	38	75	6.45	2	53	54	107	5.22	4	3	6	7	1	4	7	-	-	-
Gurung	1	4	5	2	2	4	0.46	-	13	8	21	1.89	1	5	10	25	1.22	1	-	3	1	1	1	4	-	-	-
Tembang	60	100	160	160	161	323	36.41	26	407	406	807	6.23	54	563	561	1139	55.12	50	12	73	57	48	45	123	-	3	3
Kami	4	10	14	11	12	23	2.59	1	30	27	57	4.83	7	41	33	82	3.90	8	1	6	5	3	4	9	-	-	-
Dumai	1	-	1	3	4	7	0.79	-	-	-	-	-	-	3	4	7	0.34	-	1	-	1	-	-	-	-	-	-
Others (Rel)	-	3	1	-	-	-	-	-	4	2	6	0.51	1	4	2	6	0.29	1	-	-	1	-	1	-	-	-	-
Total:-	139	181	319	437	449	886	100	78	533	575	1104	100	79	1026	1024	2050	100	157	51	113	116	37	65	200	-	3	3

Table : 1.1 b

Distribution of Household by ethnic group

Ethnic group	Household percentage
Tamang	57.4
Brahmin/Chhetri	27.3
Magar/Gurung	5.9
Newar	4.4
Kami/Damai/Others	5.0
Total - (N = 100 %)	319.00

Source - From Table 1.1.9

Population by ethnicity, age and sex in the MP cluster:

MP cluster had about 2,050 population. The 0-4 years population constituted 15.8 percent in the MP cluster of which 145 (14.1 percent) were male and 179 (17.5 percent) were female. This population was mostly from Tamang followed by Brahmin, Chhetri, Gurung, Kami, Newar and Damai and Rais respectively. The second major populated age group was 5-9 years (14 percent in the MP cluster) with similar ethnic representation as above. And it was followed by 10-14 years of age group (13.5 percent in the cluster) with similar ethnic distribution.

Of the 2050 total population, the age distribution of the sick population in the MP cluster was 18.5 percent 0-4 years of age, 19.1 percent 5-14 years of age, 38.2 percent 15-49 years of age, 17.2 percent 50-64 years and 7.0 percent was from 65 and above age group. This age distribution is amongst 78 in the MGP and 79 in the PPP. Of the 157 sick population 81 were males (51.6 percent) and 76 (48.4 percent) were female in the MP cluster (See Table 1.2 a).

The overall prevalence of sick population by sex and age is (Table 1.2 b) 18.5 percent in 0-1 years, followed by 10-14 years of age with 10.2 percent, 9.6 percent of 20-24 years of age, 8.3 percent in 5-9 years of age group and so on.

S/N	GROUP	P-CLUSTER																TOTAL		TOTAL		
		B		C		M		N		G		T		BX		D		R			N	F
		M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F			
1.	0-4	24	44	5	12	6	6	10	6	3	0	85	103	9	7	1	1	2	-	145 (14.1)	179 (17.5)	324
2.	5-9	27	36	13	12	4	8	6	7	2	2	85	72	7	5	-	-	-	-	144 (14.0)	142 (13.9)	286
3.	10-14	34	31	13	11	4	3	6	11	1	1	78	77	5	2	-	-	-	-	141 (13.7)	136 (13.3)	277
4.	15-19	31	31	13	13	6	5	5	6	2	0	64	56	2	6	-	-	-	-	123 (12.0)	117 (11.4)	240
5.	20-24	26	21	3	2	2	5	8	7	0	0	55	49	3	6	1	1	1	1	79 (9.6)	92 (9.3)	141
6.	25-29	22	14	6	7	4	2	4	3	0	2	43	47	3	3	0	1	-	-	87 (8.5)	79 (7.7)	166
7.	30-34	8	10	4	2	2	2	3	3	0	2	28	28	4	2	-	-	-	-	49 (4.8)	49 (4.3)	98
8.	35-39	9	9	0	4	2	2	1	2	3	0	19	24	3	1	-	-	-	-	37 (3.6)	42 (4.1)	79
9.	40-44	11	8	3	2	4	1	2	2	0	0	25	37	1	0	-	-	-	-	46 (4.5)	50 (4.9)	96
10.	45-49	8	7	2	4	3	3	2	0	1	0	15	13	0	0	0	1	-	1	31 (3.1)	29 (2.8)	60
11.	50-54	4	8	5	1	0	0	0	1	1	0	20	18	1	1	-	-	-	-	31 (3.1)	29 (2.9)	60
12.	55-59	7	9	2	2	1	0	2	4	1	1	11	13	2	3	-	-	1	-	27 (2.6)	30 (2.9)	57
13.	60-64	9	3	1	4	1	2	0	0	0	1	20	11	1	1	1	-	-	-	33 (3.2)	22 (2.1)	55
14.	65 +	9	7	3	0	0	1	4	2	1	1	16	15	0	2	-	-	-	-	33 (3.2)	28 (2.7)	61
	Total	1229	1238	73	76	39	40	53	54	15	10	569	561	41	39	3	4	4	2	1026	1024	2050
	Grand Total	-	467	-	149	-	17	-	107	-	25	-	1170	-	60	-	7	-	6	-	-	-

Table : 1.2 a

Ques all prevalence of sick population by age & sex in Maheshpur
Gadi, Pidan Pokhari & MP cluster

S.No.	Age groups (years)	M. Gadi			P. Pokhari			Both village panchayat					Remarks
		M	F	Total	M	F	Total	M	F	Total	%		
1.	0 - 4	5	8	13	8	8	16	13	16.00	16	21.10	29	18.50
2.	5 - 14	12	4	16	9	4	13	21	25.00	8	11.80	29	19.10
3.	15 - 49	13	16	29	17	15	32	30	37.12	31	39.50	61	38.29
4.	50 - 64	4	9	13	7	7	14	11	13.65	10	11.00	21	17.20
5.	65- above	5	2	7	1	3	4	6	7.40	5	6.60	11	7.00
Total -		39	39	78	42	37	79	81	100	76	100	157	100

Source : Field work

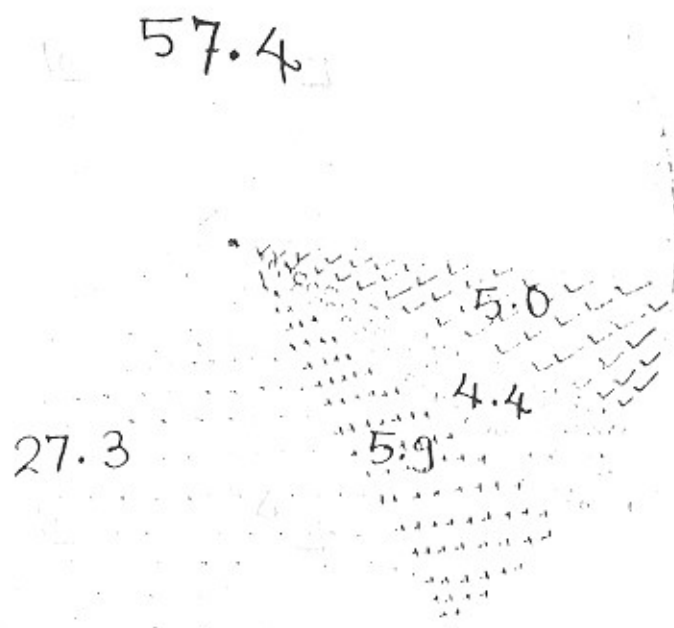
Table : 1.7 P

Over all prevalence of sick population by age & sex in Malawanpur
Gality, Padam Taluk, S. M. District

S.No.	Age groups years	H. Gadri		P. Pokhari		Both village panchayat				Remarks		
		M	F	Total	M	F	Total	M	F		Total	
1	0-4	5	8	13	0	0	14				27	10.5
2	5-9	5	1	6	4	3	7				13	8.3
3	10-14	7	5	12	5	1	6				16	10.2
4	15-19	4	4	8	2	2	4				12	7.6
5	20-24	5	2	7	3	3	6				13	9.6
6	25-29	1	3	4	5		5				9	5.7
7	30-34	1	3	4	1	4	5				9	5.7
8	35-39	1		1	3	2	5				6	3.8
9	40-44				2	3	5				5	3.2
10	45-49	1	2	3	1	1	2				5	3.2
11	50-54		2	2	1	3	4				6	5.1
12	55-59	2	4	6	3	2	5				11	7.0
13	60-64	2	3	5	3		3				8	5.1
14	65 +	5	2	7	1	3	4				11	7.0
		32	32	70			79				157	100

Distribution of Household by Ethnic Group.

Pie-Chart



INDEX

- Tamang
- Brahmin/chhetri
- Magar / Gurung
- Newar
- Kami / Samai / others

Marital Status by ethnicity in the cluster

Nepal is an independent Hindu Kingdom with other various religious groups. The distinct pattern of marriage occurs in Nepalese society. The consanguinal taboo but the same caste adoption for marriage is the output of the Hindu philosophy for marriage. Arranged, elopement, love marriage is adopted even in the outside caste group. They have separate type of marriage ceremony practices which is enculturating, acculturating with each other. In some of the caste/ethnic/tribal/non-tribal groups they have child marriage system even the law has prohibited it, and widow/widower, widow only, and inter caste marriage is practicing over the country. The marital age group is 16 and 18 for the female and male respectively but marriage below these ages also have been practiced.

The people in the MP cluster were all: married, unmarried, widow-widower, separated etc. Out of 2050 population, 1124 were unmarried, 863 married, 6 separated and 57 widow-widower. The unmarried population highest was in the Chhetri group (59.1 percent) followed by Newar (57.9 percent), Tamang (55.1 percent), Brahmin (54.8 percent), Kami (51.2 percent), Magar (49.4 percent), Gurung (44.9 percent) and Damai and others (30.8 percent).

But the married population in the MP cluster was highest in the Damai and other families (69.2 percent) followed by Gurung (56.0 percent), Magar (45.6 percent), Kami (45.0 percent), Tamang (41.9 percent), Brahman (41.8 percent),

Newar (40.2 percent), and Chhetri (38.2 percent), respectively. The separated family was 5 (0.4 percent) of the Tamang and 1 (0.2 percent) of the Brahman. The widow/widower population in the cluster was Magar (5.0 percent) followed by Kami (3.8 percent), Brahman (3.2 percent), Chhetri (2.7 percent), Tamang (2.8 percent), and Newar (1.9 percent). (Table 1.3 a.).

The under 15 years unmarried male and female were 432 (74.3 percent) and 454 (83.8 percent) respectively. 15 - 49 years population was 25.4 percent male and 16.2 percent female in the unmarried population whereas the married were 75.1 percent male, 84.2 percent female, widow 20.0 percent male and 11.9 percent female, separated 33.3 percent male and 66.7 percent female. The 50 years and above population of unmarried was 0.3 percent male only; 24.9 percent male and 15.8 percent female were married, 80.0 percent widow population was male and 88.1 percent female. Separated male were 66.7 percent and 33.3 percent was female. (Table 1.3 b.).

So the majority (54.8 percent of the total population) were unmarried, 42.1 percent married, only 0.3 percent separated, and 2.8 percent widow/widower in the MP cluster. Out of 54.8 percent unmarried population, 21.1 percent were below 15 years of age.

Table - 1.3 a.

Marital Status by Ethnicity in M. Gadi, P. Pokhari & MP cluster
Marital Status by persons

S. No.	Ethnic Group	M. Gadi				Total	P. Pokhari				Total	M.P. Cluster				Total
		Unmarried	Married	Separated	Widow		Unmarried	Married	Separated	Widow		Unmarried	Married	Separated	Widow	
1.	Brahmin	134 (52.42)	157 (44.73)	1 (0.28)	3 (2.57)	351 (100)	72 (62.06)	38 (32.77)	-	6 (5.17)	116 (100)	256 (54.82)	135 (41.76)	1 (0.21)	15 (3.21)	467 (100)
2.	Chhetri	66 (60.56)	41 (37.61)	-	2 (1.83)	109 (100)	22 (55.00)	16 (40%)	-	2 (5%)	40 (100)	88 (53.06)	57 (38.26)	-	4 (2.68)	149 (100)
3.	Magar	15 (40.54)	18 (48.65)	-	4 (10.81)	37 (100)	24 (57.15)	18 (42.85)	-	-	42 (100)	39 (49.37)	36 (45.57)	-	4 (5.06)	79 (100)
4.	Newar	16 (50%)	16 (50%)	-	-	32 (100)	46 (61.33)	27 (36%)	-	2 (2.67)	72 (100)	62 (57.54)	43 (40.19)	-	2 (1.37)	107 (100)
5.	Gurung	2 (50%)	2 (50%)	-	-	4 (100)	9 (40.65)	12 (57.15)	-	-	21 (100)	11 (44%)	14 (56%)	-	-	25 (100)
6.	Thakur	169 (52.32)	142 (43.96)	3 (0.93)	9 (2.79)	329 (100)	454 (56.26)	331 (41.02)	2 (0.25)	20 (2.47)	807 (100)	623 (55.13)	423 (41.86)	5 (0.44)	29 (2.57)	1130 (100)
7.	Khami	14 (80.87)	8 (34.76)	-	1 (4.35)	23 (100)	27 (47.37)	28 (43.12)	-	2 (3.51)	57 (100)	41 (51.25)	36 (45%)	-	3 (3.75)	80 (100)
8.	Dasari	2 (28.57)	5 (71.43)	-	-	7 (100)	-	-	-	-	-	2 (23.57)	5 (71.43)	-	-	7 (100)
9.	Others	-	-	-	-	-	2 (33.33)	4 (66.67)	-	-	6 (100)	2 (33.33)	4 (66.67)	-	-	6 (100)
Total -		452	389	4	25	866	656	474	2	32	1164	1124	853	6	57	2250

Figure in brackets indicates percentage.

Source: Field work.

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Contd./

Age group	Male %	Female %	Grand Total	Percentage
< 15 Yrs.	432 (42.1)	454 (44.3)	886	43.2
15 - 49	472 (46.0)	463 (45.2)	935	45.6
50 +	122 (11.9)	107 (10.5)	229	11.2
Total	1026	1024	2050	100

The educational status of the Nepalese people is lower than the other developing as well as developed countries. The literacy rate in 1952/54 was 5.3 percent, 8.9 percent in 1961, in 1971 it was 14.3 percent and 23.5 percent in 1981 and now it is projected around 34 percent. The literacy rate by percentage in 1986 was 51.8 percent male and 18.0 percent female with the total of 34.8 percent which is 32.8 percent in the rural and 62.7 percent in the Urban areas of the country (CBS Demographic sample survey 1986/87, First report 1987).

In the MP cluster 0 -4 years age group was 15.8 percent and the other illiterate percentage was 40.8 percent. The other 45 percent were literate. Among them 14.6 percent was just literate, followed by below five class school study (12.5 percent), 9.5 percent was primary passed, 6.8 percent was only school admitted, 1.3 percent secondary (school final or grade ten passed) and 0.3 percent had intermediate education.

The educational status by ethnicity showed the highest illiteracy among Kami, Damai and others (Rai) followed by Tamang (62.2 percent), Magar-Gurung (55.7 percent), Newar (43 percent) and Brahman - Chhetri (41.4 percent). But the literacy rate was found highest in Magar-Gurung (17.3 percent) and lowest in Tamang (14.0 percent). (Table: 1.4). Due to the low literacy rate the population was engaged in the self-medication.

Table : 1.4

Distribution of total population by educational status & ethnicity

Educational Status	Tamang %	Brahmin- Chhetri %	Magar- Gurung %	Newar %	Kami, Damai and others %	Total %
Illiterate	62.2	41.4	55.7	43.0	69.9	55.0
Literate	14.0	15.1	17.3	15.9	15.0	14.6
Only school admitted	7.1	5.2	8.7	11.2	6.5	6.8
Below five class	11.3	15.6	8.7	15.9	6.5	12.5
Primary passed	5.2	18.1	8.7	11.2	2.1	9.5
Secondary passed	0.1	3.4	-	2.8	-	1.3
Inter passed	0.1	0.8	0.9	-	-	0.3
Bachelor passed	-	0.2	-	-	-	-
Master passed	-	0.2	-	-	-	-
Total (N= 100%)	1130 (55.1)	616 (30.0)	104 (5.1)	107 (5.2)	93 (4.5)	2050

Source: Field work.

Occupation in the Cluster

Nepal is predominated by agricultural practices with a very limited petty-industries as well as cottage and small scale manufacturing factories. 93 percent of the total population is engaged in agriculture for their subsisting economic means and the subsidiary means of economy is labouring in the industries, agriculture, pastoralism and other areas. The major occupation are :

1. Agricultural land lord, and tenants,
2. Agricultural labourers,
3. Porters,
4. Petty and small scale industrialists and labourers,
5. Highway and road construction and maintenance labourers,
6. Cow and bufallow herders,
7. Small scale Business men,
8. Rural artisans and others.

In the MP cluster the dependent population was 466 (22.7 percent of the total population), the economically active population in the MP cluster was 1584 (77.3 percent) including child labour. If, the child 0 - 14 years of age (887 persons or 43.3 percent) is excluded then the actual economically active population in the MP cluster was 56.7 percent.

In the total households of 319, 30.1 percent of the households were engaged in the farming which constitutes 20.3

percent of the total population (Table 1.5). But the major percentage was under the farming and student category which was 38.2 percent of the total households and 43.4 percent of the total population in the MP cluster. This was followed by farming group. The farming group was followed by those having three or more occupation which was 20.4 percent of the total households and 26.8 percent of total population. It includes farming, business, service, animal husbandry and labour etc. It was because of the lack of income for the livelihood from their subsisting economy because of the unequal distribution of resources and no nationalized properties existed in the production and distribution.

Table : 1.5

Occupation of the households in M. Gadi, P. Pabli and WP Cluster

S.No.	M. Gadi			Pabli			WP Cluster					
	Households	Popu- lation	Percent	House holds	Popu- lation	Percent	House holds	Popu- lation	Percent			
1.	43	31.15	144	20.60	53	29.28	178	20.11	96	30.10	302	20.33
2.	4	2.99	22	3.15	-	-	-	-	4	1.3	22	1.39
3.	1	0.73	4	0.57	1	0.55	2	0.23	1	0.3	2	0.13
4.	59	42.75	309	45.31	63	34.81	335	41.24	122	39.20	688	43.40
5.	9	2.15	10	1.72	25	13.61	39	11.19	26	3.60	111	7.09
6.	-	-	-	-	1	0.50	4	2.42	2	2.30	4	2.62
7.	28	20.53	194	27.25	37	20.44	200	25.92	65	20.40	424	26.77
8.	-	-	-	-	1	0.55	7	0.79	2	0.6	11	0.69
Total	136	100	699	100	131	100	895	100	315	100	1534	100

Source : Field work.

Settlement/Migrational Pattern and Self-Medicating Population

Nepal is the place of population exporting as well as importing country. The internal migrational pattern shows that majority of the people are leaving hills and settling into the Terai (flat lands). Also rural to urban migrational rate is higher. The international immigration and emigration also has the desperate character. Nepal accepts the foreign national permanently by law and people from another country are settling at various places.

In the MP cluster 93.9 percent (1925 persons) were living in the same village from the very beginning of which 157 (8.2 percent of the population living in the same village and 7.7 percent of the total sampled population) was ill or sick. Out of 157, 57 (36.3 percent of the total sick population, 3 percent of the population living in the same village and 2.8 percent of the total sampled population) were self-medicating. 26 persons (1.3 percent) were living outside Nepal, 96 persons (4.7 percent) were living in other villages. (Table: 1.6).

Table : 1.6

Settlement pattern of the households in M. Gadi, P. Pokhari & MP cluster

Settlement	M. Gadi					Padam Pokhari					MS Cluster					Remarks		
	Household	Total popu. %	Sick %	S. Medication	Other	Household	Total popu. %	Sick %	S. Medication	Other	Household	Total popu. %	Sick %	S. Medication	Other			
Living in the same village	-	833 (94.58)	78	27	51	12	1037 (93.38)	79	30	43	4	-	1925	157	57	100	16	93.90
Living outside Nepal	-	10 (1.13)					16 (1.37)						26					1.27
Living in other village	-	35 (3.95)					61 (5.25)						96					4.68
Others (in Jail)	-	3 (0.34)					-						3					0.15
Total - households	136 (100)	866	-	-	-	-	181 (100)	-	-	-	-	319 (100)	2050	-	-	-	-	100

Figures within the parenthesis is percentage.

Source: Field work.

Duration of Sickness

The people in any society feel sick and they practice medication or live without medications.

In the MP cluster (Table, bar chart 1.7, 1.7 a, b.) people were sick for many days. 0 - 4 days sick comprised 35 persons among whom 11 persons (31.4 percent) were self-medicating, 24 persons (68.6 percent) was not getting any medication. Likewise, 5 - 9 days sufferers were 23 persons (14.6 percent) of which 11 persons (47.8 percent of the total population of this sick duration) were self-medicating but 12 persons (52.2 percent) were not getting medication. 10 - 14 days sufferers were 16 persons (10.1 percent) of the total sick population. Out of this 8 persons (50.0 percent of this sick duration) were self-medicating but 8 persons (50.0 percent) were not getting medication. And the 15 days and above sick population was 83 (52.9 percent of the total sick population). Out of this, 27 persons (32.5 percent of this sick duration) were self-medicating but 56 persons (67.5 percent) were not getting medication.

Table : 1.7

Suffering from illness within and more than two weeks and
self medication in MGP, FPP and MP Cluster

S.No.	Duration of sickness in days	Sicks population MG;PP;Both	Self Medication						Remarks Total.; Percentage;
			Yes			No			
			MG	PP	Both	MG	PP	Both	
1.	0 - 4	16;19; 35	4	7	11	12	12	24	
2.	5 - 9	9;14; 23	5	6	11	4	8	12	
3.	10 - 14	10; 6; 16	3	5	8	7	1	8	
4.	15 +	43;40; 83	15	12	27	28	28	56	
Total -		78;79;157	27	30	57	51	49	100	157

Source: Field work.

Table : 1.7 (a)

Duration of sick population by the duration of sickness

Duration of sickness: (in days)	Medication		Total sick Population (N = 100%)
	Self (percent)	No self (percent)	
(0 - 4)	31.4	68.6	35
(5 - 9)	47.8	52.2	23
(10 - 14)	50.0	50.0	16
(15 +)	32.5	67.5	53

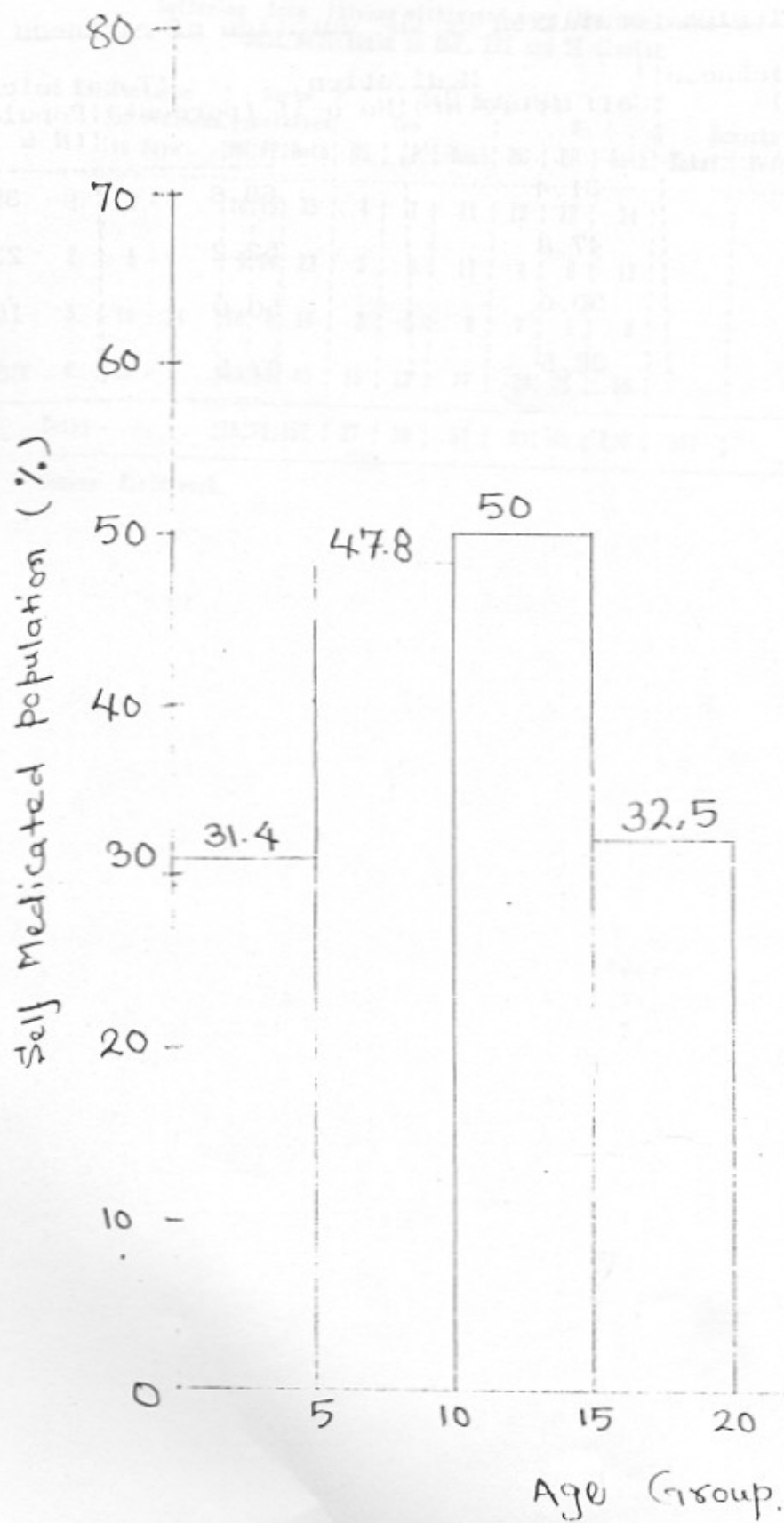


Table : 1.7 (b)

Distribution of sickness duration and self medication

Duration of sickness	Self Medicated	No self	Total
(0 - 4)	11	24	35
(5 - 9)	11	12	23
(10 - 14)	8	8	16
(15 +)	27	56	83
Total -	57	100	157

Source - From Table 1.7

Calculated value of χ^2 0.05 for 3 d.f. = 3.4

There is no significant relationship between duration of sickness & self-medication.

$$0.3 < P < 0.5$$

Family type and size in the MP cluster

Nepal is economically least developed country and people who have very few and less financial resources but an extended and joint family have a great conflicts. So that they get separated from that family.

Out of 319 households in the MP cluster, there were 200 households (87 in the MGP and 113 in the PPP) or 62.7 percent of the total households as nuclear family (husband, wife and their children). In the 200 nuclear family households there were 1061 people (449 in the MGP and 612 in the PPP) constituting 51.8 percent of the total population. This had average family size of 5.3 members. This nuclear family had 83 sick persons (7.3 percent of the total nuclear population) and 29 self-medicating population (2.7 percent of the above population). But 116 households had extended family (father-mother, son, daughter-in-law and their descendants) with 973 population (47.5 percent of the total population) with an average of 8.4 family members. There were 72 sick persons (7.4 percent of the extended family's population) and 27 self-medicating population (2.8 percent of the extended population). The joint family (father and his family, brothers and their families etc.) had 3 households having 16 persons, 2 sick and 1 self-medicating. It had an average family size of 5.3 family members (Table : 1.8).

More or less all types of families had equal percentage of self-medication practices.

Table: 1.8 a

Family types in M. Gadi, P. Pokhari & MP cluster by population and sex

Types of Family	Sick population												Self-medication											
	Households			M. Gadi			P. Pokhari			Both V. P.			M. Gadi			P. Pokhari			Both V. P.			Yes		
	NG	FP	Both	M	F	Total	M	F	Total	M	F	Total	Yes	No	Oth	Yes	No	Oth	Yes	No	Oth	Yes	No	Oth
Nuclear Family	87	113	200	21	17	38	28	19	45	47	39	83	13	25	4	15	28	2	29	54	6			
Extended Family	51	65	116	18	22	40	14	18	32	32	40	72	14	26	6	13	19	2	27	45	10			
Joint Family	-	3	3	-	-	-	1	1	2	1	1	2	-	-	-	1	1	-	1	1	-			
Total	138	181	319	39	39	78	42	38	79	80	77	157	27	51	12	30	49	4	57	100	16			

Source: Field work

Table: 1.8 b

Family Types and Population by Sex in MP Cluster

Types of Family	Population and Sex								
	MG			PF			MP Cluster		
	M	F	Total	M	F	Total	M	F	Total
1. Nuclear	220	229	449	306	306	612	526	535	1061
2. Extended	217	220	437	273	263	536	490	483	973
3. Joint	-	-	-	10	6	16	10	6	16
Total -	437	449	886	589	575	1164	1026	1024	2050

Source: Field work.

Religious Status in the MP Cluster

Nepal is the place of various religious practices with the religious tolerance. No any conflict regarding religion has occurred in Nepal. There are Hindus, Buddhist, Muslim, Christian, Jain and other religious groups.

In the MP cluster there were 909 Hindus (44.3 percent of the total population). Among Hindus 8.5 percent was sick but 35.5 percent of the total sick population was self-medicating. Buddhist were 1141 (55.7 percent of the total population). Among the Buddhist 7 percent was sick, but 37 percent of the total Buddhist sick population was self-medicating (Table: 1.9 A).

The medication in the above religious groups (Table 1.9 B) shows duplication which was seen among 12 Hindus (4.5 percent) and 5 Buddhist (1.3 percent). Under duplication Dhami-Jhankris were consulted by 27.4 percent of the Hindus and 37.4 percent of the Buddhist. Shamans by 10.9 percent Hindus and 8.1 percent Buddhist, herbals by 3.8 percent Hindus and 5.7 percent Buddhist. Modern doctor/health assistants were also contacted by 33.5 percent Hindus and 26.1 percent Buddhist, drug stores were contacted by 3.4 percent Hindus and 2.3 percent Buddhist. (Table: 1.9 B 1.9 C)

There is significant relationship between the medication pattern and religion.

The unduplication medication was very limited. Hindus using Dhami-Jhankris only were 2, Doctor/Health Assistants were 4, Drug store was 1. Buddhist using Dhami-Jhankri were only 4, Shaman 1 and Doctor/Health Assistant was 1.

(Table: 1.9 d).

Table: 1.3 A

Religious status of the households in MG, P. Pokhari and M.P. Cluster

S.No.	Religion	Total population			Illness population			Self Medication						MP Cluster			Remarks
		MG	PP	Both	MG	PP	Both	M. Gadl			P. Pokhari			MP Cluster			
								Yes	No	Oth	Yes	No	Oth	Yes	No	Oth	
1.	Hindu	552 (62.30)	357 (30.67)	909	52 (44.34)	25 (8.50)	77	15	36	8	12	13	2	27 (35.5)	49	10	
2.	Buddhist	334 (39.70)	807 (69.33)	1141	26 (55.66)	54 (7.00)	80	12	15	4	18	36	2	30 (37.0)	51	6	
3.	Muslim																
4.	Christian																
5.	Jain																
6.	Others																
Total		886 (100)	1164 (100)	2050 (100)	78	79	157	27	51	12	30	49	4	57 (100)	100	16	

Figures in parenthesis indicate percentages.

Table : 1.9 B

Duplication Medication Pattern by Religion in MG, PP, & MP Cluster

		CONSTITUTION TO																														
S.No.	Religion	Self-care			Dhoni/J.			Shamans			Herbals			Roots Grass			Vaidya			Ayurvedic			Dr./H.Asst.			Drug Store			Others			Total
		M	P	Both	M	P	Both	M	P	Both	M	P	Both	M	P	Both	M	P	Both	M	P	Both	M	P	Both	M	P	Both				
1.	HINDU	3	9	12	45	28	73	20	9	29	7	3	10	-	-	-	-	-	-	-	-	62	27	89	5	4	9	24	20	44	165 MC 100 PP 265 Both	
2.	BUDDHIST	1	4	5	55	83	143	2	29	31	7	7	14	4	4	8	-	-	-	-	-	40	60	100	-	9	9	34	39	73	143 MC 240 PP 383 Both	
3.	MUSLIM																															
4.	CHRISTIAN																															
5.	JAIN																															
6.	OTHER																															
Total		4	13	17	100	118	218	22	38	60	14	10	24	4	4	8						102	87	189	5	13	18	58	53	117	649	

Table : 1.3 C

Distribution of medication pattern by religion

Consultation to	Hindu %	Buddhist %	Total %
Self	4.5	1.3	2.6
Dhami/Jhankra	27.4	37.4	33.3
Shamans	10.9	8.1	9.3
Herbals, Roots, Grass and Leaves	3.8	5.7	4.9
Doctor & H. Asst.	33.5	26.1	29.1
Drug store	3.4	2.3	2.8
Others (Elder friends, Sudeni)	16.5	19.1	18.0

There is a significant relationship between the medication pattern & religion.

$$\chi^2 = 17.0$$

$$0.001 < P < 0.01$$

$$\text{i.e. } P < 0.001$$

Table : 1.9 d

ENTOMOLOGICAL MEDICATION PATTERNS BY RELIGION IN M.S. P. POCHARI A MP CLUSTER

S.No., Religion	CONSUMED TO										Others	Remarks		
	Self	Dhami/J.	Shamans	Herbals	Roots Grass	Vaidya	Ayurvedic	Dr./H. Asst.	Drug Store					
	M : P	Both	M : P	Both	M : P	Both	M : P	Both	M : P	Both	M : P	Both	Total	
1. HINDU	1	1	2	2	-	-	-	-	2	2	4	1	1	2 M 6 P
2. BUDDHIST	-	-	1	3	4	-	1	1	-	-	-	-	-	8 Both
3. MUSLIM	-	-	-	-	-	-	-	-	-	-	-	-	-	1 M 5 P
4. CHRISTIAN	-	-	-	-	-	-	-	-	-	-	-	-	-	6 Both
5. JAIN	-	-	-	-	-	-	-	-	-	-	-	-	-	
6. OTHERS	-	-	-	-	-	-	-	-	-	-	-	-	-	
Total	1	1	1	5	6	1	1	1	1	1	4	1	1	2 3 5

Types of Ownership and duration of houses in the MP cluster

Nepal has many villages and above 41 percent of the population is below the poverty line. The houses are mostly made of straw with muddy wall and are poor ventilated.

In the MP cluster 315 families (98.7 percent) had their own houses, 3 families (1.0 percent) had rented and only one family (0.3 percent) had given on rent. 155 sick and 55 self-medicating persons had their own houses.

Table 1.14 shows the situation of the drinking water facilities in the MP cluster. 39.2 percent of the sampled household used clean tap water and had 59 percent sick population. The unsafe tap was used by 4.1 percent of the sampled households who had 3 percent sick population. Safe dug well was used by 6.3 percent of the sampled households had 7 percent sick population. But the unsafe dug well was used by 48.9 percent of the sampled households which had 86 percent of the sick population.

Table 1.16 shows latrine facilities in the MP cluster. 83.4 percent of the households used near by forest for defaecation and had 87.9 percent sick population.

Table : 1.10

Types of Houses with duration of households

127

S.No.	Kinds	Households			Year of house made												Total			Remarks		
		0 - 1			1 - 3			3 - 5			5 - 7			7 - +								
		MG	PP	BOTH	MG	PP	BOTH	MG	PP	BOTH	MG	PP	BOTH	MG	PP	BOTH	MG	PP	BOTH			
1	ROOF																					
	a. STRAW	100	107	207	4	7	11	13	7	20	14	15	29	7	13		62	65		100	107	64.9
	b. TIN	12	10	24	4		4		3	3	1	2	3	4	1		3	6		12	12	7.5
	c. TYLEE	26	60	86	6	5	11	5	8	13	3	11	14	2	9		10	27		26	60	27.0
	d. SCONE																					
	e. PLASTERED		2	2					1	1		1								2		0.6
	f. WHITE																					
	g. RED																					
	h. OTHER	1	2	3																		
	i. WOOD	73	111	184																		
	j. BRICK-CLAY	76	11	87																		
	k. BRICK-CEMENT	1	3	4																		
	l. KIDNEY	1	2	3																		

S.No.	Kinds	Households			Year of house made												Total			Remarks
		0 - 1			1 - 3			3 - 5			5 - 7			7 - +						
		MG	PP	BOTH	MG	PP	BOTH	MG	PP	BOTH	MG	PP	BOTH	MG	PP	BOTH	MG	PP	BOTH	
3	1. STONE + PLASTER	1	1	2																
	2. FINE WOOD	1	2	3																
	3. FLOOR																			
	4. ONLY HUT	24	26	50																
	5. STONE	114	147	251																
	6. CONCRETE		10	10																
4	1. STONE																			
	2. STONE	10	50	40																
	3. STONE	104	151	255																
	4. STONE	1		1																
	5. STONE																			
	6. STONE																			
TOTAL					14			10			10			10			70			

Table 1.1:

Measurement with repair conditions of the houses in MC, PP & MF cluster

S.No.	Structure	REPAIR CONDITION			NO OF ROOMS												MEASUREMENT OF THE ROOM												REMARKS
					1 - 2			3 - 5			5 - +			SMALLER			BIGGER			SMALLER			BIGGER						
		MC	PP	BOTH	MC	PP	BOTH	MC	PP	BOTH	MC	PP	BOTH	MC	PP	BOTH	MC	PP	BOTH	MC	PP	BOTH	MC	PP	BOTH				
1	ROOF																												
	1.	10	15	25	120	164	284	15	12	27	3	5	8	57	32	89	99	148	295	7	3	10	12	14	25				
	2.	7	10	17																									
	3.	3	6	11																									
2	FLOOR																												
	1.	8	4	3																									
	2.	14	23	40																									
	3.	2	1	3																									
3	WALL																												
	1.	4	8	11																									
	2.	10	10	10																									
	3.	10	10	10																									

S.No.	Structure	REPAIR CONDITION			NO OF ROOMS									MEASUREMENT OF THE ROOM												REMARKS
					1 - 2			3 - 5			5 - +			SMALLER			BIGGER			SMALLER			BIGGER			
		MG	PP	BOTH	MG	PP	BOTH	MG	PP	BOTH	MG	PP	BOTH	MG	PP	BOTH	MG	PP	BOTH	MG	PP	BOTH	MG	PP	BOTH	
4	DOOR																									
	1.	2	6	8																						
	2.	13	15	23																						
	3.	5	12	17																						
5	WHOLE HOUSE																									
	1.	40	45	85																						
	2.	34	74	108																						
	3.	44	25	70																						
6	TOTAL																									
	1.																									
	2.																									
	3.																									

Code : 1 = Good
2 = Fair
3 = Poor

Table 1.11 (a)

Distribution of H.H. by H.H. type of the wall

WALL	NO. OF HOUSE	PROPORTION
Straw	3	0.9
Wood	225	70.5
Stone + Mud	87	27.3
Raw + Brick	4	1.3
Modern	22	6.9
Stone + Plastered	2	0.6
Fire Wood	3	0.9
Total	346	

Source : From Table 1.10

N.B. : By duplication.

Table : 1.11 b

Distribution of P. 1. 2. 3. 4. 5. 6. 7. 8. 9. 10. 11. 12. 13. 14. 15. 16. 17. 18. 19. 20. 21. 22. 23. 24. 25. 26. 27. 28. 29. 30. 31. 32. 33. 34. 35. 36. 37. 38. 39. 40. 41. 42. 43. 44. 45. 46. 47. 48. 49. 50. 51. 52. 53. 54. 55. 56. 57. 58. 59. 60. 61. 62. 63. 64. 65. 66. 67. 68. 69. 70. 71. 72. 73. 74. 75. 76. 77. 78. 79. 80. 81. 82. 83. 84. 85. 86. 87. 88. 89. 90. 91. 92. 93. 94. 95. 96. 97. 98. 99. 100.

Store,	Box or house N
Single	13.1
Double	86.2
Three	0.3
Total (N = 100%)	31.0

Source : From Table 1.10

Table 1.11 C

Distribution of H.R. by construction duration

Duration of house made (Years)	No of house Percent
(0 - 1)	8.2
(1 - 3)	11.6
(3 - 5)	14.7
(5 - 7)	11.3
(7 +)	54.2
Total (N = 100%)	319

Source : From Table 1.10

Table 1.11 d

Distribution of H.H. by type of roof

Kind	No. of house percent
Straw	64.9
Tin	7.5
Tiles	27.0
Stone	0.6
Plastered	0.6
Total (H = 100 %)	319

Source : From Table 1.10

Table 1.11 e

Distribution of H.H. by its floor

Floor	No. of house	Proportion %
Only mud	50	15.7
Dung	261	81.8
Cemented	10	3.1
Total	321	

Source : From Table 1.10

N.B. By duplication.

Table : 1.12 (a)

Distribution of H.H. by no. of rooms

No. of Rooms	No. of H.H. %
--------------	---------------

(1 - 2)	89.0
-----------	------

(3 - 5)	8.5
-----------	-----

(5 +)	2.5
---------	-----

Total (N = 100 %)	100.00
---------------------	--------

Source : From Table 1.11

Table 1.12 b

Distribution of H.H. by kind of ownership

Kind of ownership	No. of Household Percent	Population Percent
Own	98.7	99.2
Rented	1.0	0.6
Own + given on rent	0.3	0.2
Total (N = 100 %)	319	2050

Source : From Table 1.12

Table 1.12 (c)

Distribution of H.H. by members living in one H.H.

Person living	No. of H.H. held, percent
(1 - 3)	16.3
(4 - 6)	50.1
(7 - 9)	22.9
(10 - 12)	6.6
(13 - 1)	4.1
Total - (N = 100 %)	100

Source : From Table 1.12

Table : 1.13

Sources of light and cooking energy in M.G., P.Pokhari & EP cluster

S.No.	Source of Light	Households			Cooking energy Households			Total Population			Remarks
		MG	PP	Both	MG	PP	Both	MG	PP	Both	
1	Electricity		42	42				871	285	285	
2	Silver Lamp	136	139	275				15	879	1750	
3	Lanterns	2								15	
Total				181				886	1164	2050	
Cooking Energy											
4	Wood				138	181	319	886	1164	2050	
5	Others										
Total					138	181	319	886	1164	2050	

Source : Field Work.

Table 1.15 (a)

Distribution of total population (H.H.) by Sources of Light

Sources of Light	H.H.	Population Percent	Total Population	Percent
Electricity	42	13.3	305	13.9
Silver Lamp	275	86.2	17.50	85.4
Lantern	2	0.6	15	0.7
Total	319		3050	100

Source : From Table : 1.13

N.B. : By duplication.

S/No	DRINKING WATER	HOUSE - HOLDS		PUBLIC		C - 0.5		DISTANCE IN K.M.		Total H.E. H.E. (Per 1000)	Slope Per 1000										
		M' P' Both	M' P' Both	M' P' Both	M' P' Both	M' P' Both	M' P' Both	M' P' Both	M' P' Both												
1.	SAFE TAP	11	1	12	36	77	113	43	47	90	4	24	28	7	7	125	29.2	23	36	50	
2.	UNSAFE TAP	2	-	2	2	9	11	3	6	9	1	2	3	-	1	1	13	4.1	2	1	3
3.	SAFE WELL	-	-	-	2	18	20	2	13	15	-	4	4	-	1	1	20	6.3	2	5	7
4.	UNSAFE WELL	2	1	3	78	75	153	68	54	122	10	20	30	2	2	4	186	42.9	45	37	85
5.	RIVER	-	-	-	5	-	5	5	-	5	-	-	-	-	-	-	5	0.5	2	-	2
TOTAL		15	2	17	123	179	302	121	120	157	15	50	65	2	11	13	319	11.0	69	69	127

Table 1.15

Alternative Water sources in M.Gadi, P.Fekhari & HP cluster

S.No.	Source and condition (Table 1.14)	Households (X)		Percentage of the total house hold	Remarks
		M.Gadi	PP		
1.	Not Yet Dried	130 (94.22%)	174 (96.13%)	304 95.30	
2.	Neighbour's tip and stone uproot.	-	-	-	
3.	River	4 (2.89%)	6 (3.32%)	10 3.13	
4.	Others	4 (2.89%)	1 (0.55%)	5 1.57	
Total		138	181	319 100%	

Source :- Field work.

Table 1.16

Types of latrine in H. Gadu, P. Pakhar & KP cluster.

S.No.	Type of Latrine	Used by the			Illness population		
		MG	PP	Both	MG	PP	Total
1.	Any place	3	18	21	-	8	8
2.	Near to forest	129	137	266	75	63	138
3.	Latrine inside the House	-	-	-	-	-	-
4.	Out side the House	6	36	32	-	-	-
5.	Sewerage	-	-	-	-	-	-
6.	No sewerage	-	-	-	-	-	-
7.	Sanitated	1	5	6	1	2	3
8.	Not sanitated	5	19	24	2	6	8
9.	Floor with stone	-	-	-	-	-	-
10.	Slightly High-up	-	-	-	-	-	-
11.	Sulav	-	-	-	-	-	-
12.	Others (Bambo+leaves)	-	2	2	-	-	-
Total		138	191	319	78	79	157

N.B. : 3 Out side house includes No. 7,8,9,10,11,12.

Source : Field work.

Production, income and ownership of land:
(Subsisting and Subsidiary Income Status)

Nepal is the poorest country in the world where per capita income is below US\$ 100.

People in the MP cluster had various types of ownership and subsisting as well as subsidiary means of economy. The major productions in the cluster were, paddy by 99 households, maize by 314 household (98.4 percent), millet by 29 (93.1 percent) households, Soyabeans by 36 (11.3 percent) households. Wheat by 17 households (5.3 percent) and other cash crops production 2 households with the duplication of production. (Table 1.17).

The earning per month of the people in the cluster was heterogenous. The main (subsisting) income was more than Rs. 701/- in 20.7 percent households. The lowest subsisting income was below Rs. 100/- in 3.1 percent households.

The practice of animal husbandry helped to support the necessities of the household economy. Chicken occupied 55 percent among the 1-6 animals followed by goat (19.5 percent), cow (12.6 percent), oxen (9.7 percent), buffalo (2.8 percent) and pig and others (Table - 1.18)

The ownership of land by ethnic group in the MP cluster is shown in the table 1.19 below. There were 147 households (46.1 percent) who had less than one bighan of land of which 137 (42.9 percent) had their own land and 10 households (3.1 percent) had

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rented land. 1-5 bighas ownership was with 173 households (54.2 percent) of which 163 (93.9 percent) had own land and 4 households (1.2 percent) had taken on rent. Only one household (0.3 percent) had 5-10 bighas of own land in the cluster.

Ethnically the land possession was highest with Tamangs, 104 households (32.6 percent) had less than one bighas of land and 98 household (30.7 percent) possessed own lands and 6 households (1.9 percent) had rented lands. 1-5 bighas of land was possessed by 82 Tamang households (25.7 percent) of which 78 households (24.4 percent) had own land. This was followed by Brahmans who had less than one bighas of land by 10 households, 1-5 bighas own-land by 55 households. Also it was followed by Chhetri, Magar, Newar, Kami etc. (Table - 1.19).

Due to the various causes people were enforced to practice self-medication among which poverty was a major cause. To practice self-medication people possessed kit-box with some traditional and modern medicines in the house. Only 5 households had kit-box which included two households each of the Newar and Tamang and one Brahmin. (Table - 1.21.)

Monthly Income and Production (Crops) in M. Gadi, F. Pokhari and MP cluster

Income in Rs.	Main Income			Subsidiary			Major crops	No. of Households		
	M. Gadi	F. Pokh.	Both VP	M. Gadi	PP	Both (%)		M. G.	PP	Both
0 - 100	3	7	10 (3.1%)	4	3	7 (6.6%)	1. paddy -	48	51	99
100 - 150	18	9	27 (8.5%)	2	7	9 (8.5%)	2. Maize -	137	177	314
150 - 200	17	19	36 (11.3%)	6	5	11 (10.4%)	3. Millet -	134	163	297
200 - 250	16	13	29 (9.1%)	14	1	15 (14.2%)	4. Soyabean	5	31	36
250 - 300	1	5	6 (1.9%)	3	2	5 (4.7%)	5. Wheat -	5	12	17
300 - 350	14	32	46 (14.4%)	1	1	2 (1.9%)	6. Others	-	2	2
350 - 400	1	2	3 (0.9%)	-	-	-				
400 - 450	17	15	32 (10.0%)	1	2	3 (2.8%)				
450 - 500	16	20	36 (11.3%)	2	-	2 (1.9%)				
500 - 550	-	1	1 (0.3%)	-	-	-				
550 - 600	2	4	6 (1.9%)	2	3	5 (4.7%)				
600 - 650	-	2	2 (0.6%)	-	-	-				
650 - 700	6	13	19 (6.0%)	2	5	7 (6.6%)				
700 +	27	39	66 (20.7%)	23	17	40 (37.7%)				
Total -	139	181	319	60	46	106 (100%)				

Source :- Field work.

Table: 1.13

Animal Husbandry in MG, PP, & MP cluster by Ethnicity

S.No.	ETHNIC Group	HOUSEHOLDS			COW			OXEN			BUFFALO			PIG			CHICKEN			GOAT			OTHERS			TOTAL		
		MG	PP	Both	MG	PP	Both	MG	PP	Both	MG	PP	Both	MG	PP	Both	MG	PP	Both	MG	PP	Both	MG	PP	Both	MG	PP	Both
1.	BRAMHIN/ JAISI	46	17	63	89	46	136	59	26	85	63	16	79	-	-	-	84	75	159	221	51	172	-	-	-			
2.	CHHETRY	16	6	22	46	4	50	33	4	37	9	3	12	-	-	-	51	37	88	66	4	70	-	-	-			
3.	MAGAR	6	8	14	19	8	27	7	5	12	-	-	-	2	1	3	48	30	78	28	12	40	-	-	-			
4.	NEWAR	4	10	14	8	19	27	8	29	37	4	1	5	-	-	-	17	159	176	3	12	15	-	-	-			
5.	TAMANG	60	123	183	100	227	327	89	182	271	4	31	35	4	9	13	472	1495	1967	195	299	494	-	5	5			
6.	KAMI	4	10	14	7	7	14	4	5	9	1	-	1	-	-	-	26	50	76	12	12	24	-	-	-			
7.	DHAMI	1	-	1	1	-	-	-	-	-	-	-	-	-	-	-	1	-	1	4	-	4	-	-	-			
8.	SURUNG	1	4	5	-	16	16	-	10	10	-	1	1	-	-	-	-	52	52	-	8	8	-	-	-			
9.	OTHERS	-	1	1	-	-	1	-	2	20	-	1	1	-	-	-	-	25	15	-	-	-	-	-	-			
Total -		138	181	319	270	328	598	200	263	463	81	53	134	6	10	16	701	1921	2622	530	398	928	-	5	5			
Percentage		-	-	-	(12.6)	-	-	(9.7)	-	-	(2.8)	-	-	(0.3)	-	-	(55.0)	-	-	(19.5)	-	-	(0.1)	-	-	-		
Per Household		-	-	-	1.87	-	-	1.45	-	-	0.45	-	-	0.05	-	-	8.22	-	-	2.91	-	-	0.02	-	-	-		

Source: Field work.

Table 1.10

Distribution of land holdings of households in
M. Gadi, F. Bakhari & MP District (in Bigha)

S.No.	Ethnic Group	1 Bigha		1 - 5		5 - 10		10 - 15									
		O	R	O	R	O	R	O	R	O	R	O	R	O	R	O	R
1.	Brahmin	4	6	10	-	-	-	142	17	55	-	-	-	-	-	-	-
2.	Cheetri	6	2	8	-	-	-	10	3	13	-	-	-	-	-	-	-
3.	Nagar	1	7	8	-	-	-	5	1	6	-	-	-	-	-	-	-
4.	Newar	1	3	4	-	-	-	3	7	10	-	-	-	-	-	-	-
5.	Tanang	37	61	98	3	3	6	20	58	78	-	4	4	-	1	1	-
6.	Pishwakarna or (BK) Kani	3	6	9	-	2	2	1	1	2	-	-	-	-	-	-	-
7.	Danai	-	-	1	-	1	-	-	-	-	-	-	-	-	-	-	-
8.	Gurung	-	-	1	-	1	-	4	4	-	-	-	-	-	-	-	-
9.	Others	-	-	-	-	-	-	1	1	-	-	-	-	-	-	-	-
Total -		52	85	137	5	5	10	81	89	169	0	4	4	0	1	1	1

Source: Field work

NB: O = Own
R = Rented.

Table 1.21

Uses of Kit-Box by ethnicity in M.Gadi, P.Pokhari & MP cluster.

S.No.	Ethnic Group	Households with Kit-Box			Percentage	Re
		M. Gadi	P.Pokhari	Both VP		
1.	Brahmin	1 (50%)	-	1	20%	
2.	Chhetri	-	-	-		
3.	Magar	-	-	-		
4.	Newar	-	2 (66.66%)	2	40%	
5.	Tamang	1 (50%)	1 (33.33%)	2	40%	
6.	Gurung	-	-	-	-	
7.	Bishwakarma(BK)	-	-	-	-	
8.	Damai	-	-	-	-	
9.	Others.	-	-	-	-	
Total		2	3	5	100%	

Source - Field work.

Self-Medicated Population (Consumers)

The preceeding discussion provided the general demographic description of age, sex, ethnicity of the total sampled households and that of total sick population. Among the sick population, the self-medicated population were interviewed to know the types, processes, methods, merits, KAP, and the causes as well as consequences of self-medication. All the self-medicating population was taken into sample. Out of 157 sick population, only 57 were self-medicating. The prevalence rate of sick population as whole was 76.6 ($157 - 2050 \times 1000$); of which male prevalence rate was 78.0 and female was 75.2. (Table 1.1. a, 1.8 and 2.1.22). The distribution of sick population by sex was 80 males and 77 females out of 1026 males and 1024 females. There is no correlation between sick population and sex. (Table 2.2 b)

The distribution of sick population and self-medicated population by ethnic group was there were 27 households with 80 sick and 30 self-medicating population of the Tamangs, followed by 58 sick and 16 self-medicating population of the twice born families (i.e. Brahmin and Chhetris), 9 sick and 6 self-medicating population of the Kami, Damai and others, 6 sick and 3 self-medicating population of the Magar and Gurungs, and 4 sick and 2 self-medicating population of the Newars making 157 sick and 57 self-medicating population in the MP cluster.

There were 53 households out of 319 which had the sick population (157 sick population). The households which had sick population (53 households) had 361 family members.

per thousand

The prevalence rate of self-medicating population by sex was 28.3 of the male 27.3 female and 27.8 in the total population. This rate by ethnicity was 26.5 of the Tamang, 3.6 of the Twice born caste group, 2.9 of the Magar and Gurung, 1.9 of the Newar and 6.5 of the Kami, Damai and others. (Table 2.6)

Table 1- 2.1.22

Total population by sex and ethnicity in the MG, PP and MP cluster.

Ethnic group	House - Holds			M. G.			P. Pokhari			total (MP)			(Self Medication)			Total sick popn			Percent
	M.G.	P. P.	Total	M.	F.	Total	M.	F.	Total	M.	F.	Total	MG	PP	Total	MG	PP	Total	
Brahmin	8/46	4/19	12/65	36	33	71	15	24	39	53	57	110	9	4	13	34	7	41	-
Chhetri	2/16	1/6	3/22	6	6	12	6	4	10	12	10	22	2	1	3	12	5	17	-
Magar	2/6	0/8	2/14	5	7	12	-	-	-	5	7	12	2	-	2	3	2	5	-
Newar	2/4	0/10	2/14	7	9	16	-	-	-	7	9	16	2	-	2	2	2	4	-
Gurung	0/1	1/4	1/5	-	-	-	5	3	8	5	3	8	-	1	1	-	1	1	-
Tamang	12/60	15/123	27/183	35	35	70	30	43	73	85	78	163	12	18	30	26	54	80	-
Rai	0/4	5/10	5/14	-	-	-	12	10	22	12	12	24	-	5	5	-	8	8	-
Danai	0/1	-	0/1	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Rai (others)	-	1/1	1/1	-	-	-	4	2	6	4	2	6	-	1	1	-	1	1	-
Total -	26/136	27/181	53/317	91	90	181	92	86	178	183	178	361	27	30	57	78	79	157	-

Source : Field work.

Table : 2.1 (a)

Proportion of the self medicated House hold.

Ethnic group	Self Medicated House holds	Total House holds	No. of self medi. H.H. per H.H. Percent
Tamang	27	183	14.8
Brahmin/Chhetri	15	87	17.2
Magar/Gurung	3	19	15.8
Newar	2	14	14.3
Kaml/Damai/others	6	16	37.5
Total -	53	319	16.6

Source - From Table 2.1.22

Table : 2.1.(b)

Distribution of sick population by sex

Ethnic group	Population		Total Percent
	Male Percent	Female Percent	
Tamang	46.4	43.8	45.2
Brahmin/Chhetri	35.6	37.6	36.6
Magar/Gurung	5.4	5.6	5.5
Newar	3.8	5.1	4.4
Kami/Damai/others	8.8	7.9	8.3
Total (N= 100%)	183	178	361

Source - From Table 2.1.22

Table : 2.1.(b)

Distribution of sick population by sex

Ethnic group	Population		Total Percent
	Male Percent	Female Percent	
Tamang	46.4	43.8	45.2
Brahmin/Chhetri	35.6	37.6	36.6
Magar/Gurung	5.4	5.6	5.5
Newar	3.8	5.1	4.4
Kami/Damai/others	8.8	7.9	8.3
Total (N= 100%)	183	178	361

Source - From Table 2.1.22

Table 2.2.23

Prevalence of self medicating population by age, sex and ethnicity in MS, PP and MP Cluster.

	MAKAWANPUR GADI VILLAGE PANCHAYAT										PADAM POKHARI VILLAGE PANCHAYAT									
	B	C	M	R	N	G	D	SK	T	B	C	M	R	N	G	D	SK	T		
	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1		
0-4	-	2	-	-						1	3	1	1					4		
5-9	-	-	1	-							1							2		
10-14	1	-	-	-						1										
15-19	-	-	-	-														1		
20-24	-	2	-	-		1				1				1						
25-29	-	-	-	-	1												1	3		
30-34	1	-	-	-						2										
35-39	-	-	-	-						1							1	1		
40-44	-	-	-	-														1		
45-49	-	-	-	-																
50-54	-	-	-	-														1		
55-59	-	-	-	-						1								1		
60-64	2	-	-	-							1									
65+	1	-	-	-													1			
Total	5	4	1	0	1	1	1	1	1	4	8	2	2	0	1	1	1	12		
G.Total	9	1	1	1	0	2	0	0	0	12	4	1	0	1	0	0	0	19		

BOTH VILLAGE PANCHAYAT														TOTAL						BOTH SEX TOTAL / GRAND TOTAL						REMARKS				
B		C		M		R		N		G		D		3K		T		M.S. TOTAL		PP TOTAL		BOTH TOTAL		PP BOTH		MS BOTH		BOTH		
M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	
1	J	1														5	4	2	5	5	2	7	7	7		7		7	14	
	0	1														2	1	0	2	2	1	2	3	3		2		5		
2																		1	0	1	0	2	0	1		1		2		
																1		0	0	1	0	1	0	1		0		1		
	2													1		1		1	3	1	1	2	4	2		4		6		
																1	3		1	3	1	3	2	4		1		5		
1																1	2	1	2	0	1	1	3	1	1	3		4		
																1	2	1	1	0	2	1	3	1	3	1	1		4	
																	3	0	0	0	3	0	3	3		0		3		
																1		1	0	0	0	1	0	0		1		1		
																	1	0	0	0	1	0	1		1		0		1	
																2	1	1	1	0	2	1	1	1		2		3		
2	1															2		2	1	1	0	3	1	1		3		4		
1																1		2	0	0	2	2	2	2		2		4		
7	6	1	1	1	0	0	1	2	0	0	0	0	0	2	3	16	14	12	15	17	13	29	28	30		27		57		

Table : 2.2

Distribution of Sick & Self medicated
Population by Ethnicity

Ethnic Group	Sick Population	Self Med. Population
Tamang	80	30
Brahmin/Chhetri	58	16
Magar/Gurung	6	3
Newar	4	2
Kami/Damai/Others	9	6
Total -	157	57

Source - From Table 2.1.22 & 2.1.23

Table : 2.2. (a)

Distribution of sick & self
medicated population by Ethnic group

$$\begin{aligned}\text{Prevalence rate of sick population as whole} &= 157/2050 \times 1000 \\ &= 76.6^{\circ}/00\end{aligned}$$

$$\begin{aligned}\text{Prevalence rate of male population} &= 80/1026 \times 1000 \\ &= 78.0^{\circ}/00\end{aligned}$$

$$\begin{aligned}\text{Prevalence rate of female population} &= 77/1024 \times 1000 \\ &= 75.2^{\circ}/00\end{aligned}$$

Source - From Table 1.2.(a) & 1.8

Table : 2.2 (b)

Distribution of sick population by sex

Sex	Sick Population	No Sick	Total Population
Male	80	946	1026
Female	77	947	1024
Total -	157	1893	2050

Source - From Table 1.8

It is insignificant. χ^2 0.05 for 1 d.f. = 0.04

i.e. $p > 0.80$.

Table : 2.3 Multiple Bar Diagram

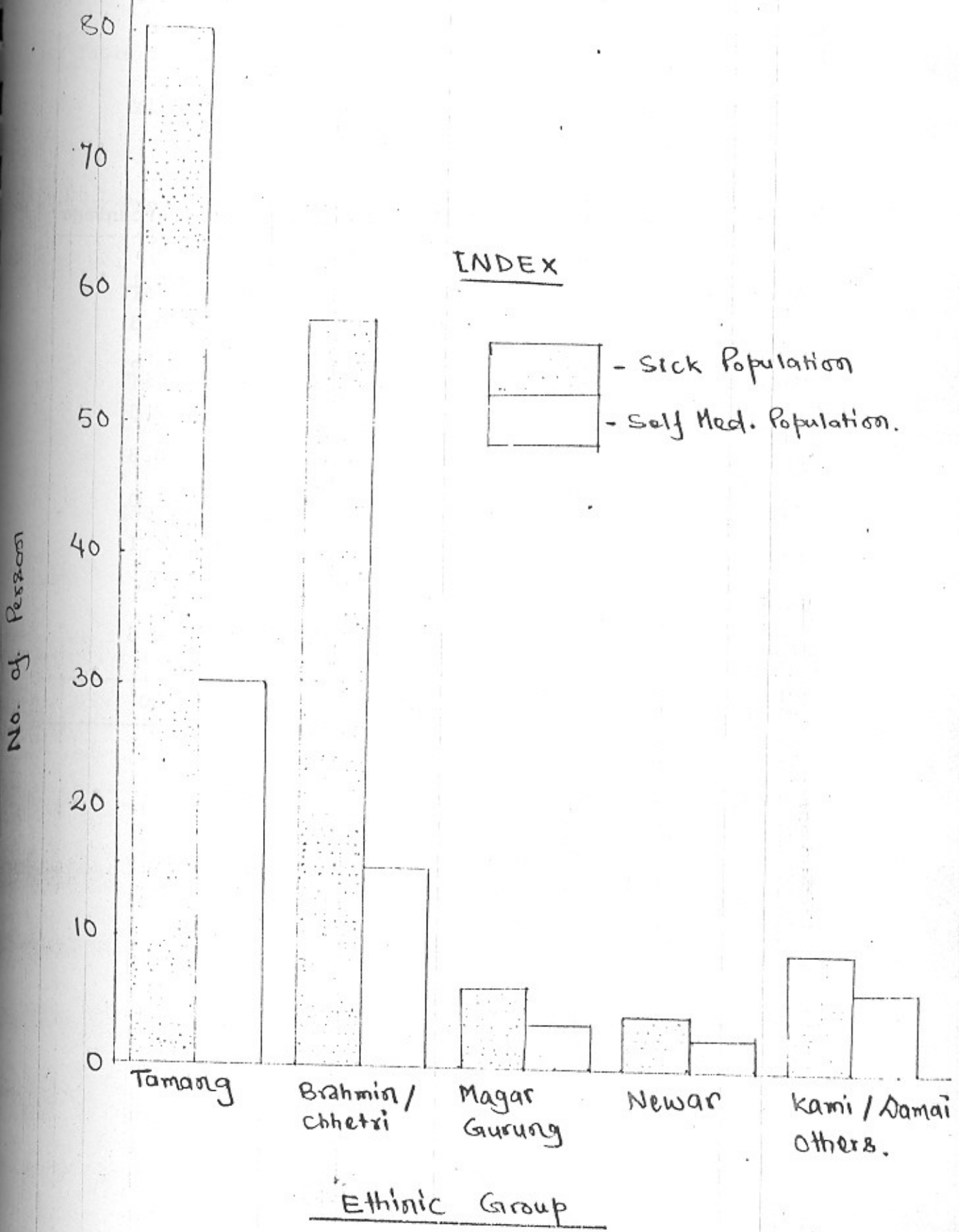


Table : 2.4

Distribution of Sick Population by Ethnicity

Ethnic Group	Total Sick Population	Percentage
Brahmin	41	26.1
Chhetri	17	10.8
Magar	5	3.2
Newar	4	2.6
Gurung	1	0.6
Tamang	80	51.0
Kami	8	5.1
Damai	-	-
Others	1	0.6
Total -	157	100

Source - From Table 2.1.22

Table : 2.5

Prevalence rate of S.M. Population by sex

$$\begin{aligned}\text{Prevalence rate of S.M. male population} &= 29/1026 \times 1000 \\ &= 28.3^{\circ} / 00\end{aligned}$$

$$\begin{aligned}\text{Prevalence rate of S.M. female population} &= 28/1024 \times 1000 \\ &= 27.3^{\circ} / 00\end{aligned}$$

$$\begin{aligned}\text{Prevalence rate of total S.M. Population} &= 57/2050 \times 1000 \\ &= 27.8^{\circ} / 00\end{aligned}$$

Source - From Table 1.2 & 2.2.23

Table : 2.6

Prevalence rate of self medicated
population by ethnic group

Prevalence rate of S.M. in Brahmin	= 13/467 X 1000	= 27.8 ⁰ /00
Prevalence rate of S.M. in Chhetri	= 3/149 X 1000	= 20.1 ⁰ /00
Prevalence rate of S.M. in Magar	= 2/79 X 1000	= 25.3 ⁰ /00
Prevalence rate of S.M. in Newar	= 2/107 X 1000	= 18.7 ⁰ /00
Prevalence rate of S.M. in Gurung	= 1/25 X 1000	= 40.0 ⁰ /00
Prevalence rate of S.M. in Tamang	= 30/1130 X 1000	= 26.5 ⁰ /00
Prevalence rate of S.M. in Kami/ Damai/		
Others	= 6/93 X 1000	= 64.5 ⁰ /00

Source - From Table 1.1 a. & 2.2.23

Prevalence and distribution of Self-medicating population by age and sex.-

In the MP cluster there were 157 sick population but only 57 were self-medicating in all ages and sex. The 0 - 4 years aged self-medicating children population was 14. It was highest among Tamang Children (9 children including 5 male and 4 female). This was followed by Brahman children (1 male and 3 females). The other ethnic groups had no 0 - 4 years self-medicating children. But as a whole this age group represents the highest one with 24.6 percent of the total self-medicating population. 5-9 years and 25-29 years age group had 8.8 percent self-medicating population. 20- 24 years aged self-medicating population was 10.5 percent in the MP cluster. Each 30-34, 35-39, 60-64 and 65 above age groups had 7.0 percent in the MP cluster. The other age groups had small self-medicating population (Table : 2.2.23 and 2.9).

Table: 2.7

Distribution of self-medicating population by ethnicity

Ethnic group	S. M. Population	Percentage
Brahmin	13	22.8
Chhetry	3	5.3
Magar	2	3.5
Newar	2	3.5
Gurung	1	1.8
Tamang	30	52.6
Kaml	5	8.8
Damai	-	-
Others	1	1.8
Total -	57	100.0

Source - from Table 2.2.23

Table : 2.8

Distribution of self-medicating population by ethnic group

Ethnic group	Self-medication	No self	Total
Tamang	30	1100	1130
Brahmin/Chhetri	16	600	616
Magar/Gurung	3	101	104
Newar	2	105	107
Kami/Damai/Others	6	87	93
Total -	57	1993	2050

Source - From table 2.1.22 & 1.1.a

It is insignificant at 5% level. Thus there is no relationship between self medication & ethnic group.

$$0.2 < P < 0.3$$

2 for 4 d.f.

$$\chi^2_{0.05} = 4.94$$

$$i. e. p > 0.2$$

Table : 2.9

Distribution of self medicating population by age group

Age group	Self medicating populating	Percentage
(0-4)	14	24.6
(5-9)	5	8.8
(10-14)	2	3.5
(15-19)	1	1.8
(20-24)	6	10.5
(25-29)	5	8.8
(30-34)	4	7.0
(35-39)	4	7.0
(40-44)	3	5.2
(45-49)	1	1.8
(50-54)	1	1.8
(55-59)	3	5.2
(60-64)	4	7.0
(65+)	4	7.0
Total (N = 100%)	57	100

Source - From table 2.2.23

Table: 2.10

Prevalence rate of S.M. Population in different age group-

Prevalence rate of S.M. Population for age group under 5 years

$$= \frac{14}{324} \times 1000$$

$$= 43.2 / 00$$

Prevalence rate of S.M. Population for age group

$$5 - 14" = \frac{7}{563} \times 1000$$

$$= 12.4 / 00$$

Prevalence rate of S.M. Population for age group

$$15 - 49 \text{ yrs} = \frac{24}{930} \times 1000$$

$$= 25.8 / 00$$

Prevalence rate of S.M. Population for age group

$$50-64 \text{ yrs} = \frac{8}{172} \times 1000$$

$$= 46.5 / 00$$

Prevalence rate of S.M. Population for age group

$$65+ = \frac{4}{61} \times 1000$$

$$= 65.6 / 00$$

Source - From table 1.2

Migration pattern in the MP cluster

Tamang group was the highest who were totally in-migrated, 20 from within the district and 8 from outside district. Tamangs who in migrated from different areas, leaving their settled places was due to the lack of the economic means, culture barriers, taboo between other higher caste and ethnic groups and others. This was followed by the Brahmin who were 13 households. The other in migrated ethnic groups were Kami 5 households, Chhetri 3 households, Magar and Newar each 2 households and Gurung and others (Rai) each 1 household, 2 households did not know their original place. (Table 2.3.24)

Table : 2.3.24

Place of settlement of the self medicating households by ethnicity in M.P. cluster

S/N	Ethnic Group	Within panchayat	Makawanpur Gadi				Padam Pokhari				M.P. Cluster				Out Side Dist.	Within Dist.
			Out side Panc-hayat	within Dist.	Out side Dist.	Within Nepal	Within Panch-ayat	Out Side Panc-hayat	Within Dist.	Out Side Dist.	Within Nepal	Within Panch-ayat	Out Side Panc-hayat	Within Dist.	Out Side Dist.	Within Nepa
1.	Brahmin	-	9	4	5	9	-	4	1	3	4	-	13	5	8	13
2.	Chhetri	-	2	2	-	2	-	1	-	1	1	-	3	2	1	3
3.	Magar	-	2	1	1	2	-	-	-	-	-	-	2	1	1	2
4.	Newar	-	2	1	1	2	-	-	-	-	-	-	2	1	1	2
5.	Gurung	-	-	-	-	-	-	1	1	-	1	-	1	1	-	1
6.	Thamang	-	10	6	4	10	1	17	11	4	18	1	17	20	8	28
7.	Khami	-	-	-	-	-	-	5	4	1	5	-	5	4	1	5
8.	Damai	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
9.	Others(Rai)	-	-	-	-	-	-	1	-	1	1	-	1	-	1	1
Total		-	25	14	11	25	1	29	20	10	30	1	54	24	21	55

Source - Field Work

Table 2.11

Distribution of S.M. population by places of settlement

Original place	Self medicating population
Within the panchayat	1
Outside the panchayat	54
Others (don't know)	2
Total -	57
Within the district	34
Outside the district	21
Others (don't know)	2
Total -	57
Within Nepal	55
Others (don't know)	2
Total -	57

Source - From table 2.3.24

Settlement duration of the Self-medicating households

In MP cluster, the people were settled for different duration, namely 0-5, 5-10, 15-20, above 20 years. There were 2 persons in two households not knowing their original place. Their settlement in the MP cluster could be due the availability of various resources (land, business and labour opportunity) (Table 2.4.25 and 2.12)

Table : 2.4.25

Settled duration and self-education pattern in the MP cluster by Ethnicity

S/N	Ethnicity	Settled duration in years																							
		Makawanpur Gadi						Not known	Padam Pokhari						Not known	MP Cluster						Not known	MG	PP	Both
		0-5	5-10	10-15	15-20	20+	0-5	5-10	10-15	15-20	20+	0-5	5-10	10-15	15-20	20+	0-5	5-10	10-15	15-20	20+	Yes	Yes	Yes	
1.	Brahmin	-	3	1	-	4	1	-	-	1	3	-	-	-	3	2	3	4	1	9	4	13			
2.	Chhetry	-	-	-	-	2	-	-	-	-	1	-	-	-	1	-	1	2	-	2	1	3			
3.	Magar	-	-	-	1	1	-	-	-	-	-	-	-	1	1	1	1	-	2	-	2				
4.	Mevar	-	-	-	1	1	-	-	-	-	-	-	-	1	1	1	1	-	2	-	2				
5.	Gurung	-	-	-	-	-	-	-	-	-	1	-	-	-	-	-	1	-	-	-	1	1			
6.	Tamang	-	-	-	2	8	1	-	2	1	3	12	1	-	2	1	5	20	2	12	18	39			
7.	Kami	-	-	-	-	-	-	1	2	-	-	2	-	1	2	-	-	2	-	-	5	5			
8.	Damai	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-			
9.	Others	-	-	-	-	-	-	-	-	-	-	1	-	-	-	-	-	1	-	-	1	1			
10.	Total	-	-	3	1	4	16	2	1	4	2	7	16	1	1	7	3	11	32	3	27	30	57		

Source : Field Work.

Table : 2.12

Distribution by settled duration & S.M. pattern in the cluster by ethnicity

Ethnic group	Settled duration in years					Not Known	Total
	(0-5)	(5-10)	(10-15)	(15-20)	(20+)		
Tanang	-	6.7%	3.3%	16.7%	66.7%	6.6%	100
Brahmin/Chhetri	-	18.8	12.5	25.0	37.5	6.2	100
Magar/Gurung	-	-	-	33.3	66.7	-	100
Newar	-	-	-	50.0	50.0	-	100
Kami/Damai/Others	16.7	33.3	-	-	50.0	-	100

Source - From table 2.4.25

Duration of illness of the Self-medicating persons

People in the MP cluster were suffering from different illnesses. The duration is important to know of the types sufferings and medication.

Tables 2.5.26 and 2.13 show the duration of illnesses of the self-medicating population by sex and ethnicity. In the M.P. cluster the higher illness was found between 0-2 weeks which covered 28 persons (49.1 percent of the total self-medicating population). It was followed by 2-51 weeks sickness covering 18 persons (31.6 percent), 1-2 and above 4 years sickness having 4 persons each (7.0 percent), 2-3 years had only 2 persons (3.5 percent).

In MP cluster, the highest number of self-medicating population in 0 - 2 weeks sickness was that of Tamang population (9 male and 3 female) and was followed by Brahmin who had 9 (6 male and 3 female) sick self-medicating population in the same illness duration.

Table : 2.5.26

Duration of illness of self-declaring persons by sex and ethnicity in MG, PP and MP cluster

S/N	Ethnicity	Sex	Makawanpur Gadi							Padam Pokhari							MP Cluster									
			0 - 2	2 - 5	5 - 1	1 - 2	2 - 3	3 - 4	4 +	Total	0 - 2	2 - 5	5 - 1	1 - 2	2 - 3	3 - 4	4 +	Total	0 - 2	2 - 5	5 - 1	1 - 2	2 - 3	3 - 4	4 +	Total
1.	Brahmin	M	5	-	-	-	-	-	5	1	2	-	-	-	-	-	3	6	2	-	-	-	-	-	-	3
		F	2	1	-	-	-	-	1	4	1	-	-	-	-	-	1	3	1	-	-	-	-	1	5	
2.	Chhetry	M	1	-	-	-	-	-	1	-	-	-	-	-	-	-	-	1	-	-	-	-	-	-	1	
		F	1	-	-	-	-	-	1	-	1	-	-	-	-	-	1	1	1	-	-	-	-	-	2	
3.	Kugar	M	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	
		F	-	1	-	1	-	-	2	-	-	-	-	-	-	-	-	-	2	-	-	-	-	-	2	
4.	Kewar	M	1	-	-	-	-	1	2	-	-	-	-	-	-	-	-	1	-	-	-	-	1	-	2	
		F	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	1	-	-	-	-	1	
5.	Garung	M	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	
		F	-	-	-	-	-	-	-	-	-	1	-	-	-	-	1	-	1	-	-	-	-	-	1	
6.	Tamang	M	1	3	-	-	-	-	4	8	5	-	-	1	-	-	14	14	9	8	-	1	-	-	13	
		F	2	3	1	-	-	-	8	1	-	2	1	-	-	-	4	3	3	3	1	-	2	-	12	
7.	Kazi	M	-	-	-	-	-	-	-	2	-	-	-	-	-	-	2	2	-	-	-	-	-	-	2	
		F	-	-	-	-	-	-	-	2	1	-	-	-	-	-	-	-	-	-	-	-	-	-	3	
8.	Dessai	M	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	
		F	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	
9.	Rai	M	-	-	-	-	-	-	-	-	-	-	-	-	-	1	-	-	-	-	-	-	-	1		
Total									27							30									57	

Source : Field Work.

Table : 2.13

Distribution of S.M. population by the duration of illness

Duration of illness	S.M. population	Percentage
(0- 2) Wks	28	49.1
(2- 51) ,,	18	31.6
(1 - 2) yrs.	4	7.0
(2 - 3) ,,	2	3.5
(3 - 4) ,,	1	1.8
(4 +) ,,	4	7.0
Total -	57	100

Source - From table 2.5.26

Symptoms of illness of the self-medicating people

The illness from which people were suffering in the MP cluster were various. 20 persons suffered from diarrhoeal diseases (35.1 percent of the total self-medicating population), only 4 used modern medicines and the rest used traditional medicines. The modern medicines which they used was obtained from their own kit box, and/or from friends and/or from the drug shops. 5 persons (8.8 percent) suffered from vomiting and all of them used traditional medicines only. There were 7 dysentery cases (12.2 percent), 3 used modern medicine and others used traditional medicine and/or healing practices. (Table 2.6.27)

In the M.P. cluster out of 115 self-medicating population (169.7 percent), 47 persons (40.9 percent) used modern medicines and 68 persons (59.1 percent) used traditional medicines.

Symptoms of illness in the self-sedating population in the MG, PP, and MP cluster

Symptoms	Makawanpur Gadi					Padam Pokhari					M.P. Cluster				
	Person	Modern	Traditional	Total	Percent	Person	Modern	Traditional	Total	Percent	Person	Modern	Traditional	Total	Percent
GI															
Diarrhoea	11	3	9	12	44.4	3	1	7	8	26.7	19	4	16	20	35.1
Vomiting	2	-	3	3	5.3	2	-	2	2	6.7	-5	-	5	5	8.3
Dysentery	3	1	4	5	13.5	2	1	2	2	6.7	5	3	4	7	12.2
Pain Abd.	2	-	2	2	3.5	2	1	1	2	6.7	4	1	3	4	7.0
Burning	-	-	-	-	-	2	2	-	2	6.7	2	2	-	2	3.5
& Yellow eye	-	-	-	-	-	1	-	1	1	3.3	1	-	1	1	1.7
Lump	1	-	1	1	1.7	-	-	-	-	-	1	-	1	1	1.7
Prolapse	1	-	1	1	1.7	-	-	-	-	-	1	-	1	1	1.7
Re-															
Breathlessness	2	2	-	2	3.5	1	-	1	1	3.3	3	2	1	3	5.3
sp. Cough	2	2	-	2	3.5	4	3	2	5	13.7	6	5	2	7	12.2
Chest pain	-	-	-	-	-	1	1	1	2	6.7	1	1	1	2	3.5
Eys-															
Blood in sputum	-	-	-	-	-	1	1	1	2	6.7	1	1	1	2	3.5
tom Indrawings	-	-	-	-	-	1	1	1	2	6.7	1	1	1	2	3.5
Gene															
Fever	10	6	4	10	17.5	13	7	7	14	46.7	23	13	11	24	42.1
ral Headache	2	2	-	2	3.5	3	1	2	3	10.3	5	3	2	5	8.3
sym Bodyache	1	-	1	1	1.7	3	1	3	4	13.3	4	1	4	5	8.3
pto Weakness	-	-	-	-	-	1	-	1	1	3.3	1	-	1	1	1.7
as Runche	-	-	-	-	-	1	1	1	2	6.7	1	-	1	1	1.7
Burning feet	-	-	-	-	-	1	-	1	1	3.3	1	-	1	1	1.7
Swelling	2	-	2	2	3.5	-	-	-	-	-	2	-	2	2	3.5
Orth															
Joint Pain	1	-	1	1	1.7	2	-	2	2	6.7	3	-	3	3	5.3
opae Stiffness	1	1	1	2	3.5	-	-	-	-	-	1	1	1	2	3.5
diaz Sprain	-	-	-	-	-	1	1	1	1	6.7	1	1	1	2	3.5
Eye/															
Red eye	-	-	-	-	-	2	1	1	2	6.7	2	1	1	2	3.5
ENT Eye discharge	-	-	-	-	-	2	2	-	2	6.7	2	2	-	2	3.5
Orth															
Bleeding	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
ers Wounds	2	2	-	2	3.5	2	2	2	4	6.7	4	4	2	6	10.5
Injury	-	-	-	-	-	-	2	1	2	6.7	2	1	1	2	3.5
Total	44	19	29	48	117%	58	29	39	68	227%	102	47	68	115	169.7

Source: Field Work.

Methods of Self-medication

There are many methods which people use to medicate either by themselves or taking suggestion/help from others. Self-medication includes different process/methods to different people. People use traditional healers (Dhami-Jhankris, Jharphuke), priests, tantras (wisdom) on the name of god and goddess, or supernatural power is a type of self-medication. People use traditional medicines like Ayurvedic, Unani, local roots, barks, leaves, soil, ash, etc. either by themselves or seeking help from the others, is another type of self-medication. Yet another type of self-medication is going to drug shop and asking particular medicine by himself or asking from the drug seller. Sometimes medicines may be used from Kit-Box/bag, and medicine once prescribed may be used without consultation. These are also self-medication.

Table 2.7.28 shows different sources used for self-medication. 40.4 percent used shamanism and priest for self-medication. It was followed by 40.3 percent getting modern medicine from drug store. 24.6 percent was using traditional medicines like roots, grasses, leaves, stones, ash, barks, fruits etc.

Methods of Self-medication (SM) in Padam Pokhari, Makawanpur Gadi
and MP Cluster.

S/N	Method	M.Gadi		Padam Pokhari		MP Cluste	
		persons	% of self Med.	persons	% of self Med.	Persons	%
1.	Buying Modern Medicine	9	33.3	14	46.66	23	40.3
2.	Roots/Tra- ditional Medicine	8	29.6	6	20.00	14	24.6
3.	Shamans/ Priests	10	37.1	13	43.33	23	40.3
4.	Vaidyas Medicine	-	-	1	3.3	1	1.8
Total -		27	100%	34	113.32	61	108.9

Source : Field Work

N.B. - By duplication.

Recovery from Symptoms

Table 2.7.28 shows, about 60 percent of the total self-medicating population was using traditional medicines and healing. 78.9 percent of the self-medicating population were not recovered even after commencement of the therapy for their illnesses. (Table 2.8.29 and 2.15)

Table : 2.4.29

Recovery from symptoms in self-medication population of Padua Pokhari, M.Gadi, and MP cluster

DURATION OF RECOVERY FROM THE ILLNESS														IN DAYS NOT RECOVERED					
M. Gadi & Padma Pokhari																			
Types	0-1	2-3	4-5	6-7	14+	Not recovered	0-1	2-3	4-5	6-7	14+	Not recovered	Both VP	0-1	2-3	4-5	6-7	14+	Not recovered
From the commencement of therapy	3	3	-	-	1	Total 20	-	2	1	-	.	Total 25	3	5	1	-	3	Total 45	

Source : Field Work.

Table : 2.15

Distribution of recovery from symptoms of
self medicating population

Period for recovery	Recovery from the symptoms after commencement of the therapy	%
(0 - 1)	3	5.3
(2 - 3)	5	8.7
(4 - 5)	1	1.8
(6 - 7)	-	-
(8 - 9)	-	-
(10 - 11)	-	-
(12 - 13)	-	-
(14 +)	3	5.3
No. recovery	45	78.9
Total	57	100

Source - From table 2.8.29

Effect of Illness on Performance and Income

The people who were self-medicating in the MP cluster were either totally affected or partially affected or were not affected. Out of 57 self-medicating population 15 (26.3 percent) were totally affected to perform their duties. 14 (24.6 percent) were partially affected but 28 (49.1 percent) were not affected (Table:2.9.30 and 2.16 a.).

The monetary loss was categorised as 0-50 loss to Rs.200/- loss and having no loss. Majority of the sick population had 0-50 Rs. loss during their sick period.

The average investment in the MP cluster was Rs. 73.3 or the average loss in Rupees due to illness was Rs. 73.3. Average X = Rs 73.3 . The expenses on medicine was on the acute diseases (see table 2.6.27) than the chronic diseases. But 78.9 percent population getting self-medication was not recovered.

The Ratio/Percentage of the sick to self-medicating Population by ethnicity is as follows:- *

S/No	Ethnic group	Sick population percentage of the total ethnic population	Self-medicating population	
			Percentage of S.Medl. pop.	Percentage of Total sick ethnic pop.
1.	Brahman	41 (8.8% of the Total Br.Pop)	13 (22.8)	31.8
2.	Chhetri	17 (11.4% of the Total Ch.Pop)	3 (5.3)	17.6
3.	Magar	5 (6.3)	2 (3.5)	40.0
4.	Newar	4 (3.7)	2 (3.5)	50.0
5.	Gurung	1 (4.0)	1 (1.8)	100.0
6.	Tamang	80 (7.1)	30 (52.8)	37.5
7.	Rai	1 (16.7)	1 (1.8)	100.0
8.	Lami	8 (10.0)	5 (8.8)	62.5
Total -		157	57	36.3

* Source : Field work

Effect on illness of performance and income in the MP

Daily work	0-50	Makarapur Gadl					Padma Pokhari					MP Cluster				
		Loss in Rs.					Loss in Rs.					Loss in Rs.				
Affected	0-50	51-100 ; 101-150 ; 151-200 ; 200 +					0-50 ; 51-100 ; 101-150 ; 151-200 ; 200 +					0-50 ; 51-100 ; 101-150 ; 151-200 ; 200 +				
		No	Loss				No	Loss				No	Loss			
Totally	7	-	-	-	-	1	8	1	1	1	2	1	15	1	1	3
Partially	8	-	-	-	-	-	6	-	-	-	-	-	-	-	-	-
No effect	12	-	-	-	-	-	16	-	-	-	-	-	-	-	-	-
Total	27	-	-	-	-	1	30	1	1	1	2	1	15	1	1	3

Source : Field work

Table: 2.16 (a)

Distribution of effect of illness at work

Effect of illness	Self Med Population	Percentage
Totally	15	26.3
Partially	14	24.6
No effect	28	49.1
Total	57	100

Source : From table 2.9.30

Table: 2.16 (b)

Distribution of totally affected population by income loss in Rs.

Loss in Rs.	No. of persons (f)	Mid Pt.(m)	mf
0 - 50	9	25	225
51 - 100	1	75	75
101 - 150	1	125	125
151 - 200	-	-	-
201 - 250	3	225	675
No loss	1	-	-
Total -	15		1100

Source - From Table 2.9.30

$$\text{Average } \bar{X} = \frac{1100}{15} = \text{Rs. } 73.3$$

Average loss in Rs. due to illness = Rs.73.3

The source of information about self medication

In the MP cluster people who were self-medicating had got information from different sources. 57 self-medicating persons got information from 58 sources. 14 got information from shopkeepers of the villages. 17 persons (29.3 percent) got information from traditional healers (Dhami, Jhankris-Exorcist), 13 were self-known (22.4 percent) 11 persons received information from friends, 2 from community leaders and 1 followed the previous prescription. (Table 2.10.31)

The person using previous prescription had once contacted (before 2 years) Hetauda Hospital for acute headache and was prescribed some medicine (i.e. APC). He got relief and since then every two months or so he was buying the same medicine when he used to get pain.

Table 2.10.31

The sources of information for self-medication in
M.Gadi, P.Pokhari & the MP cluster.

S/No	Information	No. of Persons			Proportion Percentage
		M.Gadi	P.Pokhari	Both V.P.	
1.	Shope-keeper	4	10	14	24.13
2.	Dhami/Jhankri	11	6	17	29.31
3.	Friends	3	8	11	18.96
4.	Self-known	7	6	13	22.41
5.	Others (C.L.)	2	1	3	5.17
Total		27	31	58	100

Source: Field work

- Due to duplication on Dhami/Jhankri (D/J) & Shope-keeper the total number-exceeded more than 57.

Knowledge of self medicating people

The self medicating people had variable knowledge. Some of them were providers cum consumers. Out of 57, 13 persons were self known about what, when, why the medicine were provided. The sources of knowledge of these self-known were self-study (23.1 percent) and 77 percent learnt from others. (Table 2.17.a)

The percentage of self-known sharing their knowledge to others was 33.5 percent only (Table 2.11.32 and 2.18 b).

Table: 2.11.32

Knowledge of self-medication & its use in
M.Gadi, P.Pokhari & the MP cluster

S/No.	Source of knowledge	M.Gadi knowledge shared		P.Pokhari knowledge shared		M.P cluster knowledge shared		Total
		Yes	No	Yes	No	Yes	No	
1.	Self known	2	5	3	3	5	8	13
2.	Learnt from others	6	-	4	-	10	-	10

Source : Field work

Table: 2.17 (a)

Source of knowledge of self known population

Source of knowledge	population	Percentage
Self studied	3	23.1
Learnt from others	10	76.9
Total -	13	100

Source - From Table 2.11.32

Table: 2.17 (b)

Distribution by sharing/use of knowledge

Knowledge	No. of self Known population	Percentage
Shared	5	38.5
Not shared	8	61.5
Total	13	100

Source - From Table 2.11.32

Expenditure: Financial and Time in getting medicine

In the MP cluster, 57.2 percent of the total self-medicating population expended Rs.0-9. This was followed 21 percent expending more than Rs.54 (Table 2.12.33 and 2.18.a, 2.18.b). On an average Rs.19.50 was expended in getting medicine.

All the 57 self-medicating population had to spend 0-1 day for getting their medicine /service. (Table 2.12.33)

T. 2.12.33

Time & Financial Expenditure in Getting Medicines in M.Gadi, P. Pothari & the MP cluster

S/No	Financial Expenditure (Rs.)	M.Gadi Time (days)						P. Pothari Time (days)						MP cluster Time (days)				
		Persons	0-1	2-3	4-5	6-7	7 +	Persons	0-1	2-3	4-5	6-7	7 +	Persons	0-1	2-3	4-5	6-7
1.	0 - 9	15	15					18	18					33	33			
2.	9 - 18	5	5					3	3					8	8			
3.	18 - 27	-	-					1	1					1	1			
4.	27 - 36	-	-					-	-					-	-			
5.	36 - 45	1	1					1	1					2	2			
6.	45 - 54	-	-					1	1					1	1			
7.	54 -	6	6					6	6					12	12			
8.	Gift	-	-					-	-					-	-			
	Total	27	27					30	30									

Source : Field work

Table: 2.13 (a)

Distribution of financial expenditure
in purchasing medicine

Financial Expenditure (in Rs.)	S.M. Population	Percentage
0 - 9	33	57.9
9 - 18	8	14.0
18 - 27	1	1.8
27 - 36	-	-
36 - 45	2	3.5
45 - 54	1	1.8
54 +	12	21.0
Total -	57	100

Source - From Table 2.12.33

Table 2.10 (b)

Distribution of financial expenditure in purchasing medicine

Financial Expenditure	S.M. Population (f)	Mid/pt (m)	m. f.
0 - 9	33	4.5	148.5
9 - 18	8	13.5	108.0
18 - 27	1	22.5	22.5
27 - 36	-	-	-
36 - 45	2	40.5	81.0
45 - 54	1	49.5	49.5
54 +	12	58.5	702.0
Total	57		1111.5

Source - From Table 2.12.33

.. Average $\bar{X}$ = Rs. 19.5

i.e. Average expenditure in getting medicine is Rs. 19.5

Belief in the self-medication pattern

Self-medicating population in the MP cluster were asked three types of questions to check the appropriateness of the systems. About 60 percent were using traditional medicines and faith-healers and about 40 percent were using modern medicines. The table below (2.13.34) shows that 5.3 percent in the MP cluster (3 persons) had total belief in the self-medication practice used. 82.4 percent (47 persons) was hopeful in the practice used. 12.3 percent (7 person) practising self-medication was not hopeful but expressed having no other option.

Table : 2.13.34

Belief on the self-medication pattern in
M.Gadi. P.Pokhari and MP cluster

S/No	Statement	M. G.	P. P.	Both	Percentage
1.	Total belief	2	1	3	5.3
2.	Hopeful	21	26	47	82.4
3.	No hope but No other option	4	3	7	12.2
4.	Others	-	-	-	-
	Total -	27	30	57	100

Source: Field work

Alternative Sources for Self-medication

The alternative sources of self-medication in case of not getting relief were various. In the MP cluster, 15.8 percent (9 persons) responded medication in their own house as an alternative source for self-medication. 77.2 percent (44 persons) responded, searching other sources as an alternative for self-medication. 7 percent (4 persons) responded even not to have any medication as an alternative to self-medication. (Table 2.14.35)

Table: 2.14.35

Responses of alternative sources of medication in
M.Gadi, P.Pokhari and MP cluster

S/No	Alternative means	M.Gadi Respondent	P.Pokhari Resp	MP cluster Resp	MP cluster Percent
1.	Medicating at the house	8	1	9	15.78
2.	Search other source	19	25	44	77.19
3.	No Medication	-	4	4	7.01
4.	Others	-	-	-	-
Total :-		27	30	57	100

Source : Field work

Resp = Respondent

Consulting agencies as alternative sources

In the MP cluster out of those responding to search other sources, 70.7 percent were to hospital (41 persons). 10.3 percent (6 persons) were to elders and 6.9 percent (4 persons) were to health post. (Table 2.15.36)

Table: 2.15.36

Consulting agencies as alternative sources in M.Gadi, P.Pokhari & MP cluster

S/No	Agency	M. Gadi		P.Pokhari		MP cluster		proportion
		Resp	Not Resp	Resp	Not Resp	Resp	Not Resp	Percentage
1.	Hospital	20	2	21	-	41	2 (3.5%)	70.7
2.	H.Post	-	-	4	-	4	-	6.9
3.	Vaidhyas	1	-	-	-	1	-	1.7
4.	Shamans	2	-	1	-	3	-	5.2
5.	Dhami- Jhankri	-	-	1	-	1	-	1.7
6.	Others (elders)	3	-	3	-	6	-	10.3
Total		26	2	30	-	56	2	

N.B : By duplication

Source : Field work

Sources of getting medication

43.9 percent of the self-medicating population got their medication from drug-store, 31 percent got from shamans, 24.6 percent from herbals and 7 percent from others. (Table 2.16.37)

Table :2.16.37

Sources of getting Medication in M.Gadi, P.Pokhari & MP cluster

S/No	Sources of getting Medication	M.Gadi Person	P.Pokhari Person	Both Village Panchayat Person	Percentage
1.	Drug-store	11	14	25	43.9
2.	Collecting Leaves, Grass & Herbs	10	4	14	24.6
3.	Contacting shamans	6	12	18	31.6
4.	Medicine after blowing wisdom	-	-	-	-
5.	Self preparing	-	-	-	-
6.	Others	1	3	4	7.0
Total		28	33	61	

Note - By duplication

Source: Field work

Conditions for not using medicine

Out of 157 sick population only 57 were self-medicating. 57 respondents were asked regarding the conditions of not using medicines. One of them responded as, not using medicines during sick period. Three of them responded as, not using medicines during evil eye/spirit. Rest of them (93.0 percent) responded as "do not know". (Table 2.17.38.a)

The demerits/side effects of the medicines to be used were not known to 93 percent. Less than 2 percent was knowing side effects like vomiting, exacerbation of symptoms etc. (Table 2.17.38.b)

Table 2.17.3B (a)

Conditions for not using Medicines in
M.Gadi, P.Pokhari and MP cluster

S.No	Conditions	M.Gadi Person	P.Pokhari Person	MP cluster Person	Percentage
1.	Pregnancy	-	-		
2.	Anaemia	-	-		
3.	Pain	-	-		
4.	During day time	-	-		
5.	During certain days	-	-		
6.	During particular time	-	-		
7.	During sick time	1	-	1	1.75
8.	Presence of certain man/woman	-	-	-	
9.	Presence of certain man/woman	-	-	-	
10.	Age : old	-	-		
	young	-	-		
	children	-	-		
11.	Don't know	25	28	53	92.98
12.	Other - evil spirit	1	2	3	5.26
	Total -	27	30	57	100

Source: Field work

Table 2.17.38 (b)

Demerits/side effects of the Medicines to be
used in M.Gadi P.Pokhari and MP cluster

S/No	Side-effects	M. Gadi Person	P.Pokhari Person	MP cluster Person	Percentage
1.	Vomiting	1	-	1	1.8
2.	Useless if lagan (evil-eye)	-	-	-	-
3.	Useless if old medicine	-	-	-	-
4.	Bitter taste	1	-	1	1.8
5.	Exacerbation of symptoms	-	1	1	1.8
6.	Eye complication	-	1	1	1.8
7.	Others	-	-	-	-
8.	Don't known	25	28	53	93.0
	Total -	27	30	57	100

Source: Field work

Consumption of the doses

The self-medicating people in the MP cluster were taking both traditional and modern medicines. 93 percent of the self-medicating population did not respond regarding the doses of the medicines they used. One person (1.8 percent) in the padam Pokhari consumed quarter dose because of the lack of belief in the medicine. (Table 2.18.39)

Table 2.18.39

Consumption of doses in Medication in MGL PP & MP cluster

S/No	Doses	M. Gadi Person	P. Pokhari Person	MP cluster Person	Percentage
1.	Full	-	-	-	-
2.	Half	-	-	-	-
3.	Quarter	-	1	1	1.8
4.	Not taken due to:				
	- Economic condition -	-	-	-	-
	- Lack of belief	-	1	1	1.8
	- Lack of availability	-	-	-	-
	- Do not known	2	-	2	3.4
5.	No response	-	-	53	93.0
	Total -	2	2	57	100

Source: Field work

Methods of preparing medicines

The methods of preparing traditional medicines were various. The rubbing into the stones or iron was used by one (4.2 percent), grinding by 6 persons (25.0 percent), making pieces by 4 persons (16.7 percent), dissolving in water by 27.0 persons (29.2 percent), wrapping by 2 persons (8.3 percent) and cooking and boiling was used by 4 persons (16.7 percent). (Table 2.19.40 and 2.19)

Table : 2.19

Distribution on the process of medicine preparation

Medicine Preparation	No. of Household	Percentage
Rubbing	1	4.2
Grinding	6	25.0
Pieces	4	16.7
Dissolving	7	29.2
Wrapping	2	8.3
Cooking & Boiling	4	16.7
Total	24	100

Source - From Table 2.19.40

Educational status of the self-medicating population

The literacy rate by ethnicity in the HP Cluster can be seen from Table 2.20.41. The illiteracy rate of the self medicating population was higher among Tamang groups which was 43.9 percent in the M.P. Cluster, followed by Brahmans (10.5 percent), Kami (7.0 percent), Chhetri and Magar each 3.5 percent and the others like Newar, Gurung and Rai 1.8 percent each.

The highest literate percent was of Brahman which was 7.0 percent of the total self medicating population followed by Tamang 3.5 percent and Newar 1.8 percent. The rest ethnic group had no literate population.

The prevalance rate of self medicating population in illiterate group was 37.3 and in the literate group it was 16.3 (Table 2.20).

Table 2.20.41

Educational status by ethnicity of self medicating population in M. Gadi, P. Pokhari & M.P. Cluster

S.No.	Educational Status	Brahmin			Chhetry			Magar			Newar			Gurung			Tamang			Khami			Dama			Others			Total		
		M	P	Both	M	P	Both	M	P	Both	M	P	Both	M	P	Both	M	P	Both	M	P	Both	M	P	Both	M	P	Both			
1	Illiterate	5	1	6	1	1	2	2	-	2	1	-	1	-	1	1	12	13	25	-	4	4	-	-	-	-	1	1	-	-	42
2	Literate	2	2	4							1	-	1				-	2	2											15	
3	Only School Admitted	-	1	1																1			1							2	
4	Below 5 Class	1	-	1	1	-	1																							2	
5	Primary Passed	1	-	1													-	3	3											4	
6	Secondary Passed																														
7	Inter Passed																														
8	Bachelor Passed																														
9	Master Passed																														
10	Self-studied scholar																														
11	Others																														
Total		9	4	13	2	1	3	2	-	2	2	-	2	-	1	1	12	18	30	-	5	5	-	-	-	1	1	-	-	57	

N.B. Figures in parenthesis indicate percentage

Source : Field Work.

Table : 2.20

Prevalence rate of S.M. Population in illiterate group :

$$= \frac{42}{1127} \times 1000 = 37.3 \%$$

Prevalence rate of S.M. Population in literate group :

$$= \frac{15}{923} \times 1000 = 16.3 \%$$

Table : 2.21

Distribution of S.M. Population by Educational status :

Educational Status	Self Medication	No. self Medication	Total
Illiterate	42 (3.7)	1085 (96.3)	1127 (100)
Literate	15 (1.6)	908 (98.4)	923 (100)
Total	57 (2.8)	1993 (97.2)	2050 (100)

N.B. : Figures in the parenthesis are percentage.

Source - From Table 2.20.41

$$\chi^2 = 8.27 \text{ for } 1 \text{ d.f. } p < 0.05$$

It is significant i.e. there is significant relationship between educational status & self medication. $0.001 < P < 0.01$

Providers

The previous chapter provided the general structure, types, practices and general information about contacting health related agencies during their self medicating period.

In the MP cluster the self-medicating population contacted various kinds of providers. There were total of 41 providers, and all were male. They were as follows :

Table 3.1.42

S.No.	Types	HGP	PPP	MP Cluster	Percentage
1.	Traditional Healers	19(46.3%)	16(39.0)	35	85.4
2.	Modern drug sellers		2(4.9)	2	4.9
3.	Community leader cum Traditional Healer		2(4.9)	2	4.9
4.	Community Leader cum Modern drug seller	1(2.4)		1	2.4
5.	Traditional Healer cum Modern drug seller	1(2.4)		1	2.4
Total		21(51.2%)	20(48.0%)	41	100

Source : Field Work.

The above table shows that out of 41 providers 35 were (85.4 percent) traditional healers (Dhami-Jhankri, Jharphuke, Lama, priests and all the spiritual representatives) in the MP cluster. The faith healers were many in the cluster which was because of the hereditary practices, perception by the people, accultured from neighbourhood, feelings and utility due to free service except some ritual cost on the name of god or goddess or Devatas. Whatever they provide during the practices, their appropriateness is another aspect. The appropriate or inappropriateness of the therapy provided by traditional healers was responded by only 3 as appropriate and 2 inappropriate. The modern drug seller who were only 2 (4.9 percent) responded their therapy as appropriate. The community leader cum traditional healer were only 2 (4.9 percent) one responded as appropriate and the other as inappropriate. Table 3.2.43

Table 3.2.43 Providers response on therapy provided

S.No.	Type of Providers	Appropriate	inappropriate	Total with percent
1.	Traditional healers (Exorcists only)	3	2	5 (12.2)
2.	Modern Drug seller	2		2 (4.9)
3.	Ayurvedic Drug seller (traditional medicine provider)	1		1 (2.4)
4.	Community leader cum traditional healer	1	1	2 (4.9)
5.	Community leader cum modern drug seller	1		1 (2.4)
6.	Traditional healers cum traditional medicine providers	24	4	28 (68.3)
7.	Traditional medicine cum modern medicine providers	2		2 (4.9)
Total		34 (82.9%)	7 (17.1%)	41 (100)

Source : Field Work.

The above table shows that there were seven types of providers in the MP cluster. The highest concentration was of Traditional healers cum traditional medicine providers. They were 28 (68.3 percent of the total) who heal the shamanistic practices as well as provide the home made traditional medicines made of roots, grasses, leaves, water, herbs and plants etc. They also provide parts from dead bodies of the animals, birds etc. This was

followed by Traditional healer who only blows wisdom either by thrilling body or without. They were 5 (12.3 percent), followed by modern Drug sellers, community leaders, traditional and modern medicine providers. (Table 3.2.43)

Providers by Sex and Ethnicity

In the MP cluster, there were 41 providers all were male. Ethnically the providers in the MP cluster were, 13 Brahmins (29.3 percent of total providers), 4 Chhetris (9.8 percent) 21 Tamangs (51.2 percent) and the percentage of each other ethnic group was 2.4 percent (Table 3.3.44)

Table 3.3.44

Total Population of Providers by Sex and Ethnicity of M. Gadi,
P. Pokhari & MP Cluster

S.No.	Ethnic Group	Population						Percentage	Remarks
		MG		PP		Both			
		M	F	M	F	M	F		
1.	Brahmin	9		3		12		29.3	
2.	Chhetri	2		2		4		9.8	
3.	Magar			1		1		2.4	
4.	Newar								
5.	Gurung								
6.	Tamang	10		11		21		51.2	
7.	Bishwakarma			1		1		2.4	
8.	Damai			1		1		2.4	
9.	Others (Rai)			1		1		2.4	
Total		21		20		41			
		(51.2%)		(48.8%)					

Source : Field Work

Table : 3.22

Providers by ethnicity

Ethnic group	Providers	Non Providers	Total
Tamang	21	1109	1130
Brahmin/Chhetri	16	600	616
Magar/Gurung/Newar	1	210	211
Kami/Damai/Others	3	90	93
Total	41	2009	2050

Source : From Table 3.3.44

Calculated value of χ^2 0.05 for 3 d.f. = 4.30

It is insignificant

i.e. There is no significant relationship between providers & non-providers by ethnicity.

• 02 < P < 08.

Table 3.23

Prevalence rate of providers by ethnicity

Prevalence rate of providers in Tamang =	$\frac{21}{1130}$	X 1000
	0	
	= 18.6	/00
Prevalence rate of providers in Brahmin/Chhetri =	$\frac{16}{616}$	X 1000
	0	
	= 26.0	/00
Prevalence rate of providers in Magar/ Gurung =	$\frac{1}{104}$	X 1000
	0	
	= 9.6	/00
Prevalence rate of providers in Newar	= 0	
Prevalence rate of providers in Kaml/Damai/ Others =	$\frac{3}{93}$	X 1000
	0	
	= 32.3	/00

Source : from table 3.3.44

Age group of the providers

In the MP cluster all the providers were above 21 years of age. 11 providers (26.8 percent) were between 56-60 years, 7 persons between 46-50 years (17.0 percent), 4 each providers were between 36-40, 51-55 and above 66 years of age (Table 3.4.45 and 3.25)

Table 3.4.45

Population by age of the providers in M.Gadi, P.Pokhari & MF cluster

Ethnic Group

Age Group	Brahmin			Chhetri			Magar			Tamang			B.K.			Dandi			Others			Total		
	M	PP	Both	M	PP	Both	M	PP	Both	M	PP	Both	M	PP	Both	M	PP	Both	M	PP	Both	M	PP	Both
11 - 15																								
16 - 20																								
21 - 25		1	1		1	1																1	1	2 (4.9%)
26 - 30																								
31 - 35	1	1	2								1	1										1	2	3 (7.3%)
36 - 40	1		1	1		1					1	1										1	3	4 (9.8%)
41 - 45				2		2				1		1										3		3 (7.3%)
46 - 50	1		1	2						2	2	1	1	1								3	4	7 (17.0%)
51 - 55							1	1		3		3										3	1	4 (9.8%)
56 - 60	2		1	3						2	5	7						1		1		4	7	11 (26.8%)
61 - 65	1		1							1	1	2										2	1	3 (7.3%)
66 - +	2		2							1	1	2										3	1	4 (9.8%)
Total	9	3	12	2	2	4	1	1	10															41(100)

Source : Field work.

Table 3.24

Prevalence rate of providers in different age groups:

Prevalence rate of providers

2

in age group

$$(21 - 25) = \frac{\text{-----}}{205} \times 1000 = 9.8 \text{ } ^0 / 00$$

3

$$(31 - 35) = \frac{\text{-----}}{93} \times 1000 = 32.3 \text{ } ^0 / 00$$

4

$$(36 - 40) = \frac{\text{-----}}{95} \times 1000 = 42.1 \text{ } ^0 / 00$$

3

$$(41 - 45) = \frac{\text{-----}}{64} \times 1000 = 46.9 \text{ } ^0 / 00$$

7

$$(46 - 50) = \frac{\text{-----}}{78} \times 1000 = 89.7 \text{ } ^0 / 00$$

4

$$(51 - 55) = \frac{\text{-----}}{36} \times 1000 = 111.1 \text{ } ^0 / 00$$

11

$$(56 - 60) = \frac{\text{-----}}{73} \times 1000 = 150.7 \text{ } ^0 / 00$$

3

$$(61 - 65) = \frac{\text{-----}}{34} \times 1000 = 88.2 \text{ } ^0 / 00$$

4

$$(66 +) = \frac{\text{-----}}{43} \times 1000 = 88.9 \text{ } ^0 / 00$$

Source : From table 3.4.45

Table 3.25

Distribution of Providers by age group			
Age group	Providers	No. Providers	Total
21 - 30	2	357	359
31 - 40	7	181	188
41 - 50	10	132	142
51 - 60	15	94	109
61 - +	7	72	79
Total	41	836	877

Source : From table 3.4.45

(Since below 21 age group, there is no provider)

It is highly significant

$$\chi^2_{0.05 \text{ for } 4 \text{ d.f.}} = 39.07$$

$$P < 0.001$$

Marital Status of the Providers

In the MP cluster all the providers were married. Out of 41 only 4 were (9.8 percent) widower. (Table 3.5.46)

Table 3.5.46

Marital Status ethnicity of the providers in M. Gadi, P. Pokhari & MP cluster

S.No.	Ethnicity	Married			Separate	Widow	Widower		
		MG	PP	BOTH			M.G	PP	Both
1	Tamang	10	11	21					
2	Chhetri	2	2	4					
3	Brahmin	6	3	9			3		3
4	Magar		1	1					
5	Newar								
6	Gurung								
7	B.K. (Kami)							1	1
8	Damai		1	1					
9	Others		1	1					
Total		18	19	37			3	1	4

Source : Field work.

Educational Status of the Providers

The literacy rate in the MP cluster of the providers 18 (43.9 percent) were illiterate and the rest of providers were literate (Table. 3.6.47 and 3.26)

Ethnically, the illiterate providers in the MP cluster were 10 Tamangs followed by 3 Brahmins, 2 Chhetris and one each was Rai, and Kami. The literate providers were 11 Tamangs, 8 Brahmins and one each was chhetri and magar (Table 3.6.47)

ble - 3.6.47

Educational Status by Ethnicity of the providers in M. Gali,
P. Pokhari & KP Cluster
Ethnic groups

No.	Educational Status	BRAMHIN M'P'Both	CHHETRI M'P'Both	TAMANG M'P'Both	MAGAR M'P'Both	Newar	GURUNG Both	B.K. M'P'Both	DAMAI M'P'Both	OTHERS M'P'Both	TOTAL Percentage
	ILLITERATE	2	1	3	1	1	2	4	6	10	18 (43.9%)
	LITERATE	6	2	8	1	1	6	5	11	1	20 (48.8%)
	ONLY SCHOOL ADMITTED	-	-	-	-	-	-	-	-	-	-
	BELOW CLASS FIVE	1	1						1	1	2 (4.3%)
	PRIMARY PASSED										-
	SECONDARY PASSED		1	1							1 (2.4%)
	INTER PASSED										-
	BACHELOR PASSED										-
	MASTER PASSED										-
	SCHOLAR BY SELF STUDY										-
	Total	9	3	12	2	2	4	10	11	21	41 (100%)

Source :- Field work.

Table - 3.26

Distribution of providers by educational status

<u>Educational status</u>	<u>Providers</u>	<u>Non providers</u>	<u>Total</u>
Illiterate	18 (1.6)	1109 (98.4)	1127 (100) %
Literate	23 (2.5)	900 (97.5)	923 (100) %
Total -	41 (2.0)	2009 (98.0)	2050 (100) %

Source - From table 3.6.47.

Calculated value of -x 0.05 for 1 d.f = 2.07

So it is insignificant

$0.1 < p < 0.2$

Providers view on self-care practices

The providers in the MP cluster were asked whether only the poor, or rich and poor, or literate, illiterate, all of the above practiced self-medication. But the answer from providers were as follows: 36 providers replied (87.8 percent) all the rich, poor literate, illiterate used to contact them for their treatment. Only 5 providers (12.2 percent) replied that the poor practiced self medication, 4 had the view that only illiterate had contacted them but only one providers had said the rich did contact him. Thus there was duplication in reply obtained.

(Table 3.7.48)

The table shows that there is a strong attachment of culture with medication. People, who are rich and can afford financial expenses on modern medication also do self-care due to the hereditary practices, other norms, values, attitude, behaviour, religious, rituals, and socio-economic causes. They have faith in the practices which are existed at their society and which are practicing at their villages, and home neighbours.

Table - 3.7.4B

Providers view on self-medication in H. Gadi, P. Pokhari & MP Cluster

S/No.	Self-medication by	Respondents			No respondent			Total	Percentage
		M.G	P.P	Both	MG	PP	Both		
1.	Rich	1	-	1				1	2.4
2.	Poor	4	1	5				5	12.2
3.	Rich & Poor	-	-	-				-	-
4.	Literate	-	-	-				-	-
5.	Illiterate	4	-	4				4	9.8
6.	Literate & illiterate	-	-	-				-	-
7.	All above	17	19	36				36	87.8
8.	Others	-	-	-				-	-
Total -		26	20	46				46	

N.B. : By duplication

Source: Field work

Providers view on types of self-care by them and their families.

In the MP cluster, Table 3.8.49 shows, 10 providers had contacted drug store for them or for their family members. 43 providers (due to duplication) had contacted shamans. 30 providers (due to duplication) had contacted herbals.

Table - 3.8.49

PROVIDERS VIEW ON THE TYPES OF SELF CARE BY THEM AND TO THEIR FAMILIES.

S/No.	Types of Self care	Respondents			Non respondent			Total	Remarks
		MG	PP	Both	MG	PP	Both		
1.	Contacting D. store	4	6	10					
2.	Dr's Service	-	-	-					
3.	Shamans	21	22	43					
4.	Priest	-	-	-					
5.	Elders	-	-	-					
6.	Others (herbals)	20	10	30					
Total -		45	38	83 *					

N.B. by * duplication

Source :- Field work.

Causes of popularity of the providers

In the MP cluster, providers were asked about the causes of their popularity and services. There were six causes described for their popularity. 38 providers view on popularity of their services was both effective and prompt cure. 4 providers gave the reason for their popularity as people's faith, 24 providers had opinion of their cheap treatment as the cause of popularity.

Table - 3.9.50

Causes of popularity of providers in M. Gadi P. pokhari & MP cluster.

S/No.	Cause of popularity	Responded			Non Respondent			Total	Remarks
		MG	PP	Both	MG	PP	Both		
1.	Effective & cure	21	17	38 (92.7%)					
2.	People's faith	-	4	4 (9.8%)					
3.	Cheap	15	9	24 (58.5%)					
4.	Modern trend	-	2	2 (4.9%)					
5.	Save time	1	-	1 (2.4%)					
6.	Easily available	1	-	1 (2.4%)					
Total -		38	32	70					

N.B. by duplication.

Source :- Field work.

Providers view on the problems arising in
self-medication Practices -

In the MP cluster the providers were asked questions regarding their services and problems occurring with self-medication. 37 providers (90.4 percent) replied as having no problem. Only one replied that he encountered drug reaction. And one replied that the disease was not promptly cured.

Table - 3.10.51

Problems arising in practicing self medication in
M. Gadi, P. Pokhari & MP Cluster.

S/No.	Problem	Providers			Percent	Remark
		MG	PP	Both		
1.	No problem	19	18	37	90.4	
2.	Drug reaction	-	1	1	2.4	
3.	No prompt cure	1	-	1	2.4	
4.	Complications of serious disease	-	1	1	2.4	
5.	May have pus formation.	1	-	1	2.4	
Total -		21	20	41	100%	

Source :- Field work.

Providers view on the appropriateness of self medication

In the MP cluster, 31 providers had view that the practices they were providing were appropriate. They justified appropriateness as having no dissatisfaction from patients, cure and no relapse withing certain period. But 7 providers (17 percent) described their system inappropriate due to relapse and non-scientific approach. (Table 3.11.52)

Table - 3.11.52

Providers view on the appropriateness of self medication
in M. Gadi P. Pokhari & MP cluster.

S.No.	Response of Providers	Providers			Percentage	Remarks
		MG	PP	Both		
1.	Appropriate	19	15	34	83	
2.	Not appropriate	2	5	7	17	
Total -		21	20	41	100	

Source :- Field work.

Methods of collecting and preparing Medicines

In the MP cluster (Table 3.12.53), there were different ways of collecting, preparing and applying medicines by the providers. 26 providers (63.4 percent) collected leaves, 19 providers (46.3 percent) collected roots, 2 collected bark and 3 collected unknown confidential item. Most of the items were collected from the forest. Most of the collected items were refined by grinding and dissolving. These preparations were applied locally or orally.

Table - 3.12.53

Methods of collecting, preparing and using medicines in
H.G., PP & MP cluster.

S.No. ; Types	Respondent		
	M. Gadi	P. Pokhari	Both VP
1. Collected Items			
a. Leaves	18 (85.7%)	8 (40%)	26
b. Roots.	19 (90.5%)	-	19
c. Grass	14 (66.7%)	5 (25%)	19
d. Bark	-	2 (10%)	2
e. Others	-	3 (15%)	3
2. Collection Places			
a. Own field	-	1 (5%)	1
b. Buying from drug peddlers	-	-	-
c. Buying from herbals	-	-	-
d. Collection from forest	19 (90.5%)	13 (65%)	32
e. Bringing from India	-	-	-
f. Injection doctor.	-	-	-
3. Refinement			
a. Grinding	16 (85.1%)	12 (60%)	30
b. dissolving	17 (80.9%)	12 (60%)	29
c. Raw itself	-	-	-
d. Pieces	-	-	-
e. Others	-	2 (10%)	2
4. Methods of applying			
a. Swallowing	19 (90.5%)	14 (70%)	33
b. Pocketing	-	-	-
c. Local use.	3 (14.2%)	1 (5%)	4
d. Chewing	-	-	-
e. Others	-	2 (10%)	2
(as per dosage from)			

Source :- Field work.

Table : 3.13.54

Condition for not using medicines in M. Gadi, P. Pokhari & MP
Cluster

S/N	Condition	M. Gadi		Respondents		Both VP	
				P. Pokhari			
1.	Pregnancy	X	X	1	X	1	2.4%
2.	Anaemia	X	X	-	X	-	-
3.	Pain	X	-	-	X	-	-
4.	During day/time	1	X	2	X	3	7.3%
5.	During certain day	11	X	16	X	27	65.9%
6.	During particular time	3	X	4	X	7	17.1%
7.	During sick period	6	X	9	X	15	36.6%
8.	During recovery period	-	X	-	X	-	-
9.	Presence of certain man/woman	-	X	-	X	-	-
10.	Age-Old	-	X	-	X	-	-
	Youth	-	X	-	X	-	-
	Children	-	-	-	-	-	-
	Others	2	-	6	-	8	19.5%
Total -		23	X	38	X	61	

N.B.: By duplication

Source: Field Work.

Non-interviewed Providers in the cluster

Besides 41 providers, there were others informed by these providers. There were 31 other providers. Out of the 31 providers there were 2 Health Assistants (4.9 percent) and 27 Exorcists. (Table 3.14.55)

Table : 3.14.55

NUMBER OF NON-INTERVIEWED PROVIDERS IN M. GADI & P. POKHARI

S/N	Type of Providers	No. of providers		Both VP
		M.Gadi	P.Pokhari	
1.	Doctors/ H.A	-	2	2 (4.9%)
2.	Community health Leader	-	1	1 (2.4%)
3.	Sudeni	-	-	-
4.	Vaidya	-	-	-
5.	Dhami/Jhankri (Exorcist)	16	11	27 (65.9%)
6.	Priest	-	-	-
7.	Shamans	1	-	1 (2.4%)
8.	Others			
Total		17	13	31

Source : Field Work.

Distance of alternative agencies

Table 3.15.56 shows different contacting agencies by providers/families in case of not getting relief/cure. 40 providers/families contacted hospital situated at more than 4 (Kilometeres distance. 25 providers/families contacted health post situated at 1 - 2 Kilometers distance.

Table : 3.15.56

Name of alternative agency and its distance in M. Gila P. Botheri & MP Cluster

DISTANCE (KM)

S/N	Persons Contacting		0 - 1		1 - 2		2 - 3		3 - 4		4 +		No Response	
	Name of Agency	to agency	M.G.	PP	Both	M.G.	PP	Both	M.G.	PP	Both	M.G.	PP	Both
1.	DRUG HOUSE		1											
2.	HOSPITAL		40			4			3		4		23	1 51.2%
3.	HEALTH POST		25		8	10			2		2		2	1 53.7%
4.	PRIEST	-	-											
5.	SHAMAN	-	-											
TOTAL -			66		9	14		5		6		30		2

Source : Field Work.

Table 3.16.57 Medicines used (Providers)

S/N	Local Name of the Medicine	Botanical Name
1.	Madhu Jara	
2.	Chiraito .	
3.	Shankhekira	
4.	Sal Machha	
5.	Kasturi	
6.	Jethi Madhu	
7.	Dumsi ko Dara	
8.	Sete Jara	
9.	Gaida Ko Darha	
10.	Rudraksha	
11.	Baj Danga	
12.	Tama & Pathar	
13.	Gaida Ko Chhala	
14.	Machha	
15.	Jarango	
16.	Gaida	
17.	Banel	
18.	Machha Ko Thutuno	
19.	Kasturi Bhutla	
20.	Others.	

Modern Medicines-

1. Tonics
2. TT
3. ATS
4. Cough syrup
5. Paracetamol
6. Antibiotics/capsules
7. Sulpha Guanidine/Nediquin
8. ENT drops etc.

Chronic diseases - Sufferings, diagnosis and treatment by the Providers-

In the MP cluster (Table 3.17.58) people were suffering from various chronic diseases such as skin, tuberculosis, asthma and hyperacidity. There was one patient under each disease. The skin disease was diagnosed for about 2 years by the modern medical doctor and patient was getting medicine from him. Similarly tuberculosis was diagnosed for about 4 - 5 years by the modern medical doctor and patient was taking medicine from him.

Asthma also was diagnosed for about 4 - 5 years by the modern medical doctor and the patient was getting treatment from him. There was one case of hyperacidity diagnosed by traditional healer but getting treatment from modern drug store.

No kit-box was found in any providers house.

: 3.17.58

Description of
ack population suffering from chronic diseases in M. Gadi, Padam Pokhari & MP cluster

Disease	Population						When diagnosed (years)												Who diagnosed						Medicine used							
	0 - 1			1 - 2			2 - 3			3 - 4			4 - 5			Doctor			Vaidya			T. Healer			Self			Modern				
	M	P	Both	M	P	Both	M	P	Both	M	P	Both	M	P	Both	M	P	Both	M	P	Both	M	P	Both	M	P	Both	M	P	Both		
SKIN	1		1				1		1							1		1											1		1	
TUBERCULOSIS		1	1											1	1		1	1											1		1	
LEPROSY																																
MENTAL DISEASE																																
THYROID/GOITRE																																
OTHERS (ASTHMA)	1		1											1	1		1	1											1		1	
HYPERACIDITY		1	1												1	1									1	1				1		1
TOTAL	2	2	4				1		1					1	2	3	2	1	3					1	1				2	2	4	

Referral and consultation by the Provider

In the MP cluster, 40 providers (97.6 percent) had no consultation with others during self-medication. Only one provider used to consult frequently with others (health assistant).

But they used to refer cases to different places, if not relieved/cured. 29 providers in the MP cluster (70.8 percent) had referred to the modern hospital, 19 providers (46.3 percent) had referred to modern medicine practitioner and 2 providers (4.8 percent) referred to the traditional experts. 4 providers did not refer to any one. The referral was mainly verbal. (Table 3.17.60).

16 providers advised not to take oily and hot edibles, drinks. 5 providers advised not to eat meat and fishes etc. (Table 3.28).

Thus the providers in the MP cluster had good practice. They were providing services by themselves as well as consulting with others. They were also referring to the related agencies. They had impression from people, and also good status and prestige.

Table : 3.17.59

Referral and consultation by the providers In M. Gadi. P.
Pokhari & MP cluster

S/N	Statement	Respondents			No response	Remarks
		M	P	Both		
1.	Consultation with other during self medication					
	a. Each Time					
	b. Frequently		1	1		
	c. If necessary					
	d. No consultation	21	19	40		
2.	With -					
	a. Modern Doctor & H.A.		1	1		
	b. Traditional healer					
	c. Drug store					
	d. Drug Peddlers					
	e. Others.					

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If not cured they
referred to -

	a. Hospital	17	12	29
	b. Other Modern practitioner	-	19	19
	c. Traditional expert	2	-	2
By	a. Verbal	-	19	19
	b. Written			
1.	No referral	3	1	4
5.	Advice to the patient during therapy			
	a. YES	22	11	33
	b. NO	-	1	1

Source : Field Work

Table: 3.27

Distribution of providers by referral
& Consultation

S/N	Statement	Respondent (Providers)	Percent
1.	Consultation with other <u>Period</u>		
	a. Each time	-	-
	b. Frequently	1	2.4
	c. If necessary	-	-
	d. No consultation	40	97.6
	Total -	41	100

2.	With		
	a. Modern doctor's or HA	1	2.4
	b.		
	c.		
	d.		
	e.		
	f. No response	40	97.6
Total -		41	100

Source - From Table 3.17.59

Table : 3.28

Advised provide by providers

Advise to patient during therapy.	No. of Providers	Percent
Don't eat oily & hot food	16.	39.0
Wine, liquor	3	7.3
Don't eat meat & fishes	5	12.2
As per dosage form	2	4.9
Not to use Cow's milk	4	9.8
Don't touch goat	2	4.9
Use Amulet	1	2.4
Others	3	7.3
No response	5	12.2
Total -	41	100

Source - From Table 3.17.59

CONCLUSION

The chapters from introduction to providers provide the total and very important findings on different aspects in Nepal. General structure of the nation, health status of Nepalese people, governmental, non-governmental, people's participatory programmes in health status and fields are briefly stated herewith.

Nepal is the country which is situated on the slopes of Himalayas and covered by two big countries Tibet, China in the north and India in the east, west and south. Nepal has 17.9 million population among which 9.2 million are males and 8.7 are females i.e. 51.5 percent male and 48.4 percent female with the sex ratio 105.3 per 100 female. The population by the year 2000 A.D. is projected to about 23.1 million of which 12.0 million (51.8 percent male) and 11.1 (48.2 percent) female. The density of population is 122.26. The annual population growth rate is 2.6 percent. 80.4 percent population is 0 - 14 years age group and 5.3 percent above 65 years dependent population. 7.7 percent population is in the urban and 92.3 percent in the rural areas. Per hectare of arable land is 5.6.

There are 96 hospitals with 4153 beds. The crude birth rate per 1000 is 41.6, crude death rate per 1000 is 14.85, IMR per 1000 is 105.3, MMR per 1000 is 8.5, life expectation at birth is 53 years (54.4 for male and 51.6 for female). Total fertility rate is 5.8, completed family size is 5.8, gross reproduction rate is 2.8 and Net reproduction rate is 2. GNP per capita is US\$ 160.

The ratio between hospital and population is 1:180292, hospital beds and population is 1:4163, total doctors and population is 1:19691, MMG doctors and population is 1:22774, health volunteers and population is 1:3787. The same ratio is applicable in the Makawanpur district (study district).

MP cluster (includes MGP i.e. Makawanpur gadi panchayat and PPP i.e. Padma Pokhari Panchayat clusters) has the population of 2050 with 319 households and 9 ethnic groups. Among the ethnic groups the majority of population belongs to Tamang group.

Ten percent of ethnic groups, households and population were taken into sample by using random numbers after collecting the data from the respective sources.

138 households in the MGP, and 181 in the PPP (319 total), with the population of 886 (437 males and 449 females) in the MGP and 1164 (589 males and 575 females) in the PPP constituted the MP cluster.

In the MP cluster there were 157 (7.7 percent of the total population) sick population and 57 (2.8 percent of the total population and 36.3 percent of the total sick population) self-medicating population.

There was 55 percent totally illiterate and 6.8 percent school admitted but illiterate population. It means MP cluster had 61.8 percent illiterate and 38.2 literate population.

Agriculture and animal husbandary were found to be major occupations. Very few were associated in the business sector.

93.9 percent people were living in the same village/households from the very beginning. People who were sick for more than 15 days were 83 (52.9 percent of the total sick population) and the rest were within 15 days. There were 200 (62.7 percent) nuclear families and 116 extended families. There were 55.7 percent Buddhist religious group and 44.3 percent were Hindus. The houses in the cluster were mostly made of straw, poor wood, poor ventilated and which needed to be repaired. 81.8 percent houses were made of dung, 15.7 percent only of mud and 3.1 percent was cement plastered. The houses were mostly self owned (99.2 percent), 50.1 percent of total household has 4 - 6 persons. The sources of light in the houses were mainly silver lamp and hardly electricity. The sources of water was unsafe well (48.0 percent) and people using this water had 54.8 percent sick population. 83.4 percent people used open latrine in near by forest and their sick population was 87.9 percent.

Most of the people were poor. The average family had 6.4 members. The maximum monthly income of more than 700 Rs. was earned by 20.7 percent and 3.1 percent had income below Rs 100. Less than one bighas of own land was possessed by 137 households, 1-5 bighas of own land was possessed by 103 households, and only one household had more than 5 bighas of land. Only 5 households had kit-box containing traditional and/or modern medicine.

There were 53 households (16.6 percent of the total households) with 361 population (17.6 percent of the total population) which had 157 sick population (43.5 percent of the total sick's

households population). Among 157 only 57 (27 in the MGP, 30 in the PPP i.e. 2.8 percent of the total population, 36.3 percent of the total sick population) were self medicating. Self-medicating population included 52.6 percent Tsimang, 23.1 percent twice born family, and 8.8 percent Kami-Damai family. It was also found practicing in other communities. There were 29 males and 28 females (50.9 percent and 49.1 percent) self - medicating. 0-4 years age group was mostly found practised (24.6 percent), followed by 20-24 years (10.5 percent), other age group population had similar self-medication practices. Self-medicating population was migrated within district but from sperate villages. There were 32 (56.1 percent) settled since 20 years, and 11 (19.3 percent) between 15-20 years and the rest below 15 years. There were 18 (31.6 percent) self-medicating population suffering for 2-51 weeks and 28 (49.1 percent) were suffering for 0-2 weeks. 35.1 percent of the self-medicating population was suffering from diarrhoea; 12.2 percent from dysentery, 8.8 percent from vomiting, 42.1 percent from fever, 12.3 percent from cough and 5.3 percent from joint pain.

Self medication was obtained from various sources either single or in duplication. 40.3 percent contacted modern drug sellers, 26.6 percent contacted roots and traditional medicine and 40.3 percent contacted shamans/priests. 45 persons (78.9 percent) were not recovered and rest got recovered within 14 days. They were involved in the self-medication practices due to their faiths. There was no effect on work during sick time (49.1 percent), 24.6 percent was partially affected and 26.3 percent was totally

affected. However, information on self medication was received by 24.1 percent from shop-keepers (dug shop, kirana shop), 29.3 percent from Dhami/Jhankris, 19.0 percent from friends, 22.4 percent self known, and 5.2 percent from others (elders, experienced, previous user). The knowledge of self-medication of the self-known was obtained by 76.9 percent from others and 23.1 was self-studied. Out of this only 38.5 percent shared their knowledge to others. Self-medication was practiced by 5.3 percent because of total belief, 82.4 percent practised because they were hopeful and 12.3 percent were practicing due to no other option. The alternatives for self medication was reported by 77.2 percent to search other services and 7.0 percent not practising any medication. The other services included 70.7 percent hospital, 6.9 percent health post and the rest to other traditional provides. 93 percent of self-medicating population did not know the condition when not to use the practice/medicine and 5.3 percent knew that medication should not be used during evil spirit. The harmful effects of self-medication was not known to 93.0 percent but each 1.6 percent knew harmful effects like vomiting, exacerbation of symptoms etc. The monthly expenditure on medication was 0-50 Rs. for 72.0 percent, and 51-100 Rs for 15.8 percent, and Rs 301 for 5.3 percent. So the expenditure was not higher and it might be promoting self-medication.

People were involved in self medication because of low literacy rate, poor economy, lack of health facilities etc.

There were many types of providers and they can broadly divided into three categories:

- i. Modern medicine providers, doctors, paramedicals, Nurses, drug retailers and others,
- ii. Traditional medicine provides, Vaidhyas, Kabiraj and others,
- iii. Healers - Dhami-Jhankris, Shamans, Priests, Lamas, astrologers, and others.

Total number of providers were 41 and these were 4.9 percent modern drug providers, 12.2 percent exorcists (healers), 2.4 percent Ayurvedic medicine providers, 4.9 percent community leaders and the rest were mixed professionalists and practitioners. Ethnically, there were 29.3 percent Brahmin, 9.8 percent Chhetris, 51.2 percent Tamang and 9.6 percent were of other ethnic groups. The age group of providers were between 56-60 years (26.8 percent), 46-50 years (17.0 percent), and the other age groups had less than 10.0 percent. All the providers were married but 4 were widower. 43.9 percent provides were totally illiterate, and the rest were literate. 87.8 percent provides expressed their view that rich, poor, literate and illiterate practiced the self-medication. The reasons for their popularity was described as effectiveness and cure (92.7 percent respondent), cheap (58.5 percent). Their view on problems during self medication was without any problem by 90.4 percent, only 2.4 percent responded as having drug reactions. Providers were of the view that their methods for self-medication was appropriate (83.0 percent) and only 17 percent described as not appropriate. The medicines which they were using included leaves (63.4 percent),

roots, grasses etc were 46.3 percent each. These were collected from the forest (78.0 percent) and prepared by grinding (73.1 percent). Medicines which they were providing were prohibited for use during certain days (65.9 percent), during sick time (36.6 percent), during particular time 17.1 percent. Besides, 41 providers (2 percent of the total population, 26.1 percent of the total sick population and 71.2 percent of the self-medicating population) there were 31 other providers in the same or neighbouring villages of which 27 were Dharmi-Jhankris. They could not be contacted during whole study period.

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APPENDIX - QUESTIONNAIRE. (Translated from Nepali Version)

Form No. 1.

Questionnaire for demographic information of the sample
population :

Date : / /

Panchayat Ward No. Village.....

1. Name of the head of household Age.....

Caste.....

Religion

2. Name of the Respondent.....

Age.....

S.No.

Relationship with the head of the household.....

3. Family description

S.N.	Name	Sex	Age below 5yrs, (in month)	Above 5yrs	Marital Status	Occupation	Ed. status	Residence	History of any illness within two weeks. If so what has happened.	Since	Is he/she self-medicating ?
1.											
2.											
3.											
4.											
5.											
6.											

Note : (i) Marital Status : 1 = Unmarried, 2 = Married, 3 = Widw/Widower, 4 = Seperated.

(ii) Educational Status : 0 = illiterate, 1 = Only literate, 2 = Only School admitted,

3 = Below V class, 4 = Primary Passed, 5 = Secondary passed, 6 = Intermediate passed

7 = Bachelor passed (graduate), 8 = Post graduated, 9 = self - Studied Scholar.

(iii) Residence : 1 = Living in the villages, 2 = Living outside the country, 3 = Living in other places.

4: Housing/Health Infrastructure

A) Roof	B) Wall	C) Floor	D) Story
Straw	Straw, Mud	Only Mud	How many stories ?
Tin, Tile, Stone	Raw brick, Smoked Brick	Dung, Cemented, other	
Plastered (RBC, ECC)	(Unplastered/Plastered		
others	Half plastered/Out/In plastered.) others:		

E) Duration of house made : Year/ Duration

F) No. of Rooms : How many, Measurement of the room

(a) Biggest

(b) Smallest

G) Repairing condition : Roof, Floor, Wall, Window/door, Whole home

(Note:- 1 = Good , 2 = Fair, 3 = Poor)

H) Family members of that house : How many living together

I) Ownership of the house : Own, rented, Own and given on rent,

Given on rent and living outside others
house on rent.

J) Electricity : Yes/No - If not - sources of light, lamp/
lantern/others.....

K) Cooking Sources : Wood/Kerosene/Electricity/
others

L) Sources of drinking water: Protected tap/unprotected tap/ Protected
well/river/ well only/ others.

M) Distance (In KM) for water source

N) Type of water source a) Own/public,
b) if dried, alternative
sources of water

0) Latrine Places : (a) Anywhere, (b) Very near to forest, Latrine
made by them/others.....

P) If latrine, its place (a) Inside the house, (b) Outside the house
(c) Sewerage (d) No sewerage
(e) distance to reach to latrine in KM or
time

Q) Types of latrine : (a) Sanited, (b) Not sanited, (c) Floor with Stone, (d) Slightly high up, (e) Sulav
(f) Others

5. Income description

(a) Subsisting means of economy - (a) yearly average income in
(a) Grain (Maund or Kg.)
(b) Cash (Rs.).....

(b) Subsidiary means of economy :

(a) Yearly income in cash/kind.

6. Ownership of land : (a) Own/rented/own and others/given on

(a) Ownership of land in Katha.....

(b) Main crops/productions

(c) Animal husbandry : Yes/No, if yes give name

& number

7. If there is herbal production:

S.N	Name of the herbs	Area of cropping (Bigha/Ropani)
1.		
2.		
3.		
4.		
5.		
6.		
7.		

8. Have you Kit-Box ? Yes/No

(if yes, fill up the form no 3)

9. If sick, - Places for Primary Contact :

Place for Secondary Contact:

Questionnaire for Self-Medicating Person

Date:

Panchayat Ward No. Village.....

S. No.

Name of the Respondent..... Sex..... Age

1) Where was your original house ? (Dist.....Panchayat.....)

when are you settled here ? (Year

2) When did you feel sick at last ? (the latest sickness).

Year..... Month..... Date.....

3) In your opinion, what were the major symptoms ?

a) b) c) d)

4) Did you get treatment or was cured without treatment ?

5) If you had used any medication, what was the source of those medication and how did you get ?

6) How many days were you sick ?

a) From the onset of the diseases

.....

b) From the commencement of therapy

.....

7) Could you work during sick period ? Yes/No

What was type of loss ? (Financial or other loss.....)

8) Who gave you information about those medicines ?

(Shop-keeper, Exorcist/Shamans, Friends etc or were you self known ?)

9) If you were self-known, where did you get the information first ?)

Have you shared this knowledge to others ?

- 10) What was the average expenses for those medicines ?
- 11) What was the time spent in getting/preparing those medicines ?
- 12) Do you believe that medicine will cure the disease ?
- If yes :
- a) Total belief, b) Hopeful,
 - c) No hope but no option.
13. If this medicine is not helpful what will you do / you
- a. medication at the house b. search other alternative
14. If you have /had to other source, where did/do you contact ?
- Hospital/ Healthpost/ vaidhya/ shaman/ Exorcist/ Dhami Jhanki
- other .
15. How did/do you get your medicine
- Buying from drug store
 - Collecting roots/herbals,
 - Contacting healers/shamans,
 - Medicines after blowing wisdom
 - Other .
16. Do you know the demerits of those medicines : Yes / No.
- If Yes, What do you think :
- a.
 - b.
 - c.
 - d.
17. In what condition these medicines are contraindicated ?
18. What is average monthly expenditure on medicines ?
19. If this medicines were / are prescribed by the medical practitioners / health personnel, how many days did / do you take these medicines ?

20. If you could / can not take full dose, why ?

21. If you had searched yourself ;

a) What were / are the medicine - name:

b) What were / are the doses

c) How it can be prepared ?

22. Have you a kit-box ? Yes/No.

If yes use form No 3.

Form No. 3

Open Ended Questionnaire for Traditional Healers, Doctors, Sellers, and community leaders and all types of providers with self care patterns and problems.

Date

--	--	--	--	--	--	--	--

S.No.

Panchayat Ward No. Village

1) Name Age Sex.....

Ethnicity

Marital status (According to the code of Form No.1)

Educational status (According to the code of Form No.1)

2) In your opinion, what type of people do self- care ?

Rich ; Poor ; Literate ; illiterate ; All of the above

3) What type of self care patterns are available in these villages ; areas ?

a) b) c) d)

4) Will you kindly say how and why the self care pattern provided by you is popular ?

5) What are/ could be problems from the self-care ?

6) Is self care pattern appropriate ? yes / No. why ?.....

7) Will you kindly say the methods of collection, refinement, preparation and method of applying it ?

8) In what conditions / situation self care pattern cannot be done /practiced ?

9) In what condition / situation, your medication is contraindicated ?

10) Are there any other problems ? Yes / No, if yes

S.No.	Name	Caste	Address
1			
2			
3			
4			

11) Which is the first contact agency if somebody falls sick in your house ?

- a) Self medication by - collecting herbs.
- Blowing wisdom.
- Buying medicines from kirana shop.
- Using Ayurvedic medicine
- Others.

b) Contacting - Health Assistants / Modern medical practitioner / Modern drug store.

c) Vaidhya

d) Jharphuke

e) Dhamijhankri

f) Others

12. The nearest treatment agencies :-

S.No.	Name	District	Others
1			
2			
3			
4			

13) Have you any Kit-Box ? Yes/No., If Yes :-

Description of Kit-Box/Bag

S.N.	Name of the medicines	Total Dose	Brought from	Total Cost	Used or not	Who uses	Others
1.							
2							
3							
4							

14) Is there any person with chronic disease ?
(Asthma, Skin, TB, Leprosy, Gout, mental, others)

S.N.	Name of the Patient	Disease	When diagnosed	Who diagnosed	Treatment Medicine used/used
1					
2					
3					
4					
5					
6					
7					

15) Are you / some one using / used any medicine / herbal your house ? Yes/No. if Yes.

S.N.	Name of the medicine	From when	Till when	Dose	Cost/Price
1					
2					
3					
4					

16. Are there other Persons having knowledge of diseases and treatment in this community ? Yes / No. If Yes :

S.No.	Name	Age	Sex	Religion	Address	Type of (Providers/Community)	Role in the (Providers/Community)	Remarks
1.								
2.								
3.								

17. Do/did you contact with others while prescribing / diagnosing the disease. Yes / No - If Yes , a) each time b) Frequently c) other

With whom and why ?

- a.
- b.
- c.

18. Do you suggest / advice anything to the patients during your service ? Yes / No. , If Yes, What are those ?

19. If not cured from your service, do you refer the patient ? Yes / No , If Yes

How (verbal / Written)

Where

Why