

**HEALTH, ILLNESS AND MEDICATION PRACTICES
AMONG MAGARS OF TAMKIKOT HILL IN
SYANGJA DISTRICT, NEPAL**

A Dissertation

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in

SOCIOLOGY

By

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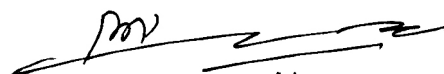
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February 2021

LETTER OF RECOMMENDATION

We certify that this dissertation entitled "**HEALTH, ILLNESS AND MEDICATION PRACTICES AMONG MAGARS OF TAMKIKOT HILL IN SYANGJA DISTRICT, NEPAL**" was prepared by candidate Mr. Bishnu Kumar Sinjali under our guidance. We hereby recommend this dissertation for final examination by the Research Committee of the Faculty of Humanities and Social Sciences, Tribhuvan University, in fulfillment of the requirements for the Degree of **DOCTOR OF PHILOSOPHY** in **SOCIOLOGY**.

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February 2021



TRIBHUVAN UNIVERSITY
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APPROVAL LETTER

This dissertation entitled **Health, Illness and Medication Practices among Magars of Tamkikot Hill in Syangja District, Nepal** was submitted by **Mr. Bishnu Kumar Sinjali** for final examination to the Research Committee of the Faculty of Humanities and Social Sciences, Tribhuvan University, in fulfillment of the requirements for the degree of **Doctor of Philosophy in Sociology**. I, hereby, certify that the Research Committee of the Faculty has found this dissertation satisfactory in scope and quality and has therefore accepted for the degree.

Prof. Kushum Shakya, PhD
Dean and Chairperson
Research Committee

Date: 30 Sep, 2021

DECLARATION

I hereby declare that this Ph.D. dissertation entitled "**HEALTH, ILLNESS AND MEDICATION PRACTICES AMONG MAGARS OF TAMKIKOT HILL IN SYANGJA DISTRICT, NEPAL**" is an entirely original work prepared under the supervision and guidance of supervisor Prof. Dr. Ritu Prasad Gartoulla and co-supervisor Assoc. Prof. Dr. Shyamu Thapa Magar and that it contains no materials previously published. I have not used these materials for the award of any kind and any other degree. Where other authors' source of information has been used, they have been acknowledged.



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ABSTRACT

This research is focused on the local perception of ill-health and medication practices of the Magars based on their own culture and social setting through sociological lenses. The Magars are indigenous people of Nepal (GoN-NFDIN, 2063 BS). Although they are found scattered all over Nepal, their main habitats are Sapta Gandaki, Rapti and Bheri river basin. They have their own traditional culture, social systems followed by three mother tongues (Magar Dhut, Magar Kham and Magar Kaike). Magar Dhut, which is widely known as Magar language, is spoken in the study area. However, in recent years, their own language, traditional culture, social norms and values, traditions, indigenous knowledge and skills are in the situation of dying mainly due to the influence of the present market, state policy, modernity and development. This research has been conducted in such a social transition phase of the Magars. It is true that "health is a common theme in most culture (Park 2005, p.12) and "health is not simply biology but involves a number of factors that are cultural, political, economic, and—specially—social in nature" (Cockerham, 2012, p.2).

This research was carried out in nine VDCs of Syangja district in Nepal where 15% of households (636) were selected through random sampling. Furthermore, 55 key informants were interviewed on the principle of information saturation in the field, and focus group discussions were conducted in each VDC. Quantitative cum qualitative (mixed) research method was applied. This work was theoretically based on structural-functionalism, however, the models of health care in local settings, social constructionist, gender and health care systems were used to answer the research questions.

The main finding of this research was that although the Magars were following bio-medicine and other medication systems in a pluralistic setting, they had their own indigenous health and medication practices at their local level. The cultural practices were being practiced for better health, good fortune and well-being. They had their own indigenous nomenclatures regarding illness, healing and health. They had a low level of knowledge of and in the government's health care system, constitutional and legal provisions. The indigenous knowledge and skills of ill-health and healings of the Magars were significantly changing and gradually replaced by the bio-medical theories and perspectives. In addition, there was a significant influence of socio-cultural backgrounds in perception towards health, illness, healings, medication practices, and biomedicine too. Therefore, it can also be argued that the relation of individuals or society with health can be influenced by the socio-cultural factors.

Key Words: Magar, ill-health, medication, medical-sociology, indigenous-knowledge

ABBREVIATION/ACRONYMS

ANM	Auxiliary Nursing Midwife
AHW	Auxiliary Health Worker
BP	Blood Pressure
CBS	Central Bureau of Statistics
CBO	Community Based Organizations
CDO	Chief District Officer
CDS	Central Department of Sociology
CEDA	Center for Economic Development and Administration, TU
CMA	Community Medicine Assistants
CNAS	Center for Nepal and Asian studies, TU
CTEVT	Council for Technical Education and Vocational Training
DPHO	District Public Health Office
DHO	District Health Office
DoHS	Department of Health Services
GNI	Gross National Income
GDP	Gross Domestic Product
GoN	Government of Nepal
HA	Health Assistant
HDI	Human Development Index
HIV/AIDS	Human Immune Virus/Acquired Immune Deficiency Syndrome
HP	Health Post
ICT	Information and Communication Technology
IKS	Indigenous Knowledge and Skill
INGO	International Non-governmental Organization
IOM	Institute of Medicine, TU
KAP	Knowledge, Attitude, Practice
KI	Key Informants
MCH	Maternal and child health
MDG	Millennium Development Goals (UN)
NGO	Non-governmental Organization
NHRC	Nepal Health Research Council
NMA	Nepal Magar Association
NPC	National Planning Commission

PHC	Primary Health Center
PHC/ORC	Primary Health Care Outreach Clinics
PLHIV	People living with HIV
PRA	Participatory Rural Appraisal
SDG	Sustainable Development Goals (of UN)
SHP	Sub-health Post
SPSS	Statistical Package for Social Sciences
STI	Sexually Transmitted Infections
TB	Tuberculosis
TU	Tribhuvan University
UMN	United Mission to Nepal
UN	United Nations
UNDP	United Nations Development Programme
VDC	Village Development Committee
WHO	World Health Organization of the UN

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CHAPTER ONE

INTRODUCTION

1.1 Background of the Study

Health, illness, medication practice and well-being are social phenomena. The discoveries and innovations in health science or medical science are for people and society, and their well-being. Being social phenomena, the "social factors play role in determining or influencing the health of individuals, groups and the larger society" (Cockerham, 2012, p.1). Furthermore, "All the communities have their concepts of health, as part of their culture" (Park, 2005, p.12). Socio-cultural factors influence perception and practices on illness, pain and other forms of misfortune, health and health care (Helman, 2007, p.3). In addition, the social and cultural context of individual plays role in primary development of the affect of illness and cultural elaboration of ill-health and health-seeking behaviours (Kleinman, 1980, p.171). Among them, the Magars are one ethnic group of Nepal. Nepalese society has medical pluralism context (Devkota, 1984; Gartoulla, 1998; Subedi, 2001; Harper, 2014). Ornamented with socio-cultural diversities, Nepal is a Himalayan country having geographical diversity ranging from the plain land Terai/Madhesh to the highest peak Sagarmatha (Mt. Everest). It is sandwiched between two geographically large countries: China and India. This geographical diversity has added biological, ecological and socio-cultural diversities.

Due to such socio-cultural, linguistic, geographical variations as well as bio-diversities, the perception of ill-health, medication practices, indigenous knowledge and skills for health and well-being, social-behaviour towards biomedicine are prevalent to diverse from society to society in Nepal. In socio-cultural diversities, "the content of the health care systems varies from society to society (depend on social, cultural, historical and economical factors), a range of healing traditions is common to all" (Gabe, Bury and Elston, 2004, pp.183-184). Similarly, health and culture are interrelated disciplines, and "health is a common theme in most cultures" (Park 2005, p.12). So, socio-cultural perception on health and illness, well-being is portrayed as per socio-cultural background of the society. The human civilization has developed their own socio-cultural norms and values, socio-cultural practices, social behaviours in their communities as per natural and social environmental adaptations. Culture is a constructed ideology that plays a vital role to influence various aspects of individual lives, including their beliefs, behaviour, perceptions, emotions, languages, religion, rituals,

family structure, diet, dress, body image, concepts of space and of time, as well as attitudes to illness, pain and other forms of misfortune – all of which may have important implication for health and health care (Helman, 2007, p.3). Hence, the perception of health, illness and health-seeking behaviours are created differently in one ethnicity/ community to another.

In the same way, the history of Nepal covers the history of synchronism of various cultures, languages, religions, ethnic groups, castes and creeds too; a model of mosaic society. It means Nepal is a garden of many castes/ethnicities, races, their language and cultures. Similarly, the Gurkha's bravery, Mount Everest and Lord Buddha are some of them being famous for their nationalism, nature creation, and historical recognition. The population of Nepal is 26,494,504 and among them 13,645,463 are female and 12,849,041 male where the annual population growth rate is 1.35 percent (CBS, Feb 2014, p.1). Like other castes/ethnic groups, the Magars also have their own culture, language, social belief system and customary social systems that distinguish them from others. Nepal has diversity in socio-cultural backgrounds. There are 125 castes/ethnicities having 123 languages where 97 of these languages are of Nepal origin (CBS, Feb 2014). In this context, here, the research title covers the health, illness and medication practices among the Magars relating to their socio-cultural background from a medical sociological eye.

The population of the Magars is 1,887,733, ranking as the third-largest population (CBS, Feb 2014, p.1). Furthermore, the Magars have a historical contribution during the time of unifying Nepal initiated by the late king Prithwi Narayan Shah as "the Magars were regarded as some of the most loyal followers of the royal family" (Regmi, 2007, p.46). Likewise, "The Magars are such a tribal people living mostly in the basin of the Gandak, but they are scattered all over the country. The Gorkhali fighters included Khasas and Magars in general" (Regmi, 2007, p.46). Despite the Magars' contribution to the democratic revolution and federal republic democratic, still, they are found remaining too back in the mainstream of the country, not being included as per the proportion of their proportion.

Furthermore, Nepal has its own history of human settlement and diffused, struggling with nature, culture development, language and social institutions while adapting natural phenomenon. Indigenous people generated their own ethnic knowledge that helps them to survive and their community development. Hence, it is found that most of the ethnic community were practicing their own medication system before the introduction of the modern-western medication system (Bio-medicine); and those medication practices were adapted according to culture, society and environment. Those traditional medication systems,

beliefs and healing are based on their culture, language, ethnicity and locality, and connected with daily life and production, the environment where people have lived; and practicing mutually with modern medicine in a pluralistic situation. Basically, the modern medical technology (Bio-medical model) developed in Europe and spread all over the world, and Nepali people were unfamiliar with the allopathic medication system before 1624 AD. Furthermore, "... the western system of medicine has been practised from about 1740 AD (1797 BS)" (Dixit, 2005, p.4). However, allopath was available in Kathmandu valley, but the ancient *Magarant* area was far from its touch. Indigenous peoples were practicing their own beliefs, shamanism using herbs and shrubs to cure illness at that time when western medicine was not propagated. Although Nepal is spending a lot of money in promoting the western medication system, peoples are struggling to get easy access to hospitals and health care, even in this modern technological era. These days, the Magars are seeking services from the western medical system; however, they are also practicing their own indigenous healing practices. In such a medical pluralistic practice situation; it is needed to study the perceptions of ill-health and medication practices among the indigenous peoples, and to understand them and explore their current situation regarding health.

1.1.1 Culture, Health and Society

Health care service is a major issue in every society and country. The government makes great effort to ensure easy access to quality health facilities for every citizen, and all the stakeholders have efforts to provide better health services to the public. In contrast, the socio-cultural background influence in consumption of provided health care through the government and other sectors, and results can be achieved differently. Hence, Cockerham (2012), mentioned as, "social factors are also important in influencing the manner in which societies organize their resources to cope with health hazards and deliver medical care to the population at large" and further he writes, "Individuals and societies tend to respond to health problems in a manner consistent with their culture, norms and values" (Cockerham, 2012, p. 1). Furthermore, "medical care and health services are acts of political philosophy" (Light and Schuller, 1986, p.9), "thus social and political values influence the choices made, institutions formed, and level of funding provided of health"(Cockerham, 2012, p. 2). In health, social factors such as social class, occupation, age, gender, ethnicity, education, geographical distribution, politics and power, and development creates inequality (Gabe, Bury and Elston, 2004), and differ in illness concept and medication practices.

Health is a social phenomenon, and it is a complex and multi-dimensional subject. Thus it is difficult to find a single and all-purpose definition; different organizations and scholars tend to define it differently. There are many concepts such as health as the absence of disease, health as normality, or the ability to function (Blaxter, 2010). Most cultures understand that 'health is an absence of disease', which is the very oldest concept about health. The broad definition is given by World Health Organization (1948) as, "health is a state of complete physical, mental and social wellbeing and not merely an absence of disease or infirmity" (Cockerham, 2012, p. 3). In recent years, this statement has been amplified to include the ability to lead a "socially and economically productive life" (Park, 2005, p.13). By this definition of health, it is giving social aspect for the health, that's why it is also respecting socio-culture aspects for better health. Culture is a part of a community that is experienced for long period and acquired by being a social member and these facts show the relation between health, society and culture.

Culture and health are interrelated; every culture has its own socio-cultural concepts about health, illness and medication in their community. Culture is a social knowledge, attitude and practice of the human-being of that particular community. Culture or civilization is taken in its wide ethnographic sense. Tylor (1871) defines culture as, "that complex whole which includes knowledge, belief, art, morals, law, custom and any other capabilities and habits acquired by man as a member of society" (Helman, 2007, p.2). Hence culture included belief, art, morals, law, custom, capabilities and habits, and other complex subjects which are acquired by a person from society being a social member. It states the relationship between health and culture. Similarly, Keesing and Strathern (1998) stated, "culture comprises; systems of ideas, systems of concepts and rules and meaning that underline and are expressed in the ways that human beings live" (Helman, 2007, p.2). This definition has stressed the ideational aspect of culture. The ideational aspect is important in the concept of ill-health, sickness, disease and medication. Helman (2007) argues, "the modern view of culture is to stress the importance of always seeing it within its particular context" (Helman, 2007, p.4). Further, he describes, "this context is made up of historical, economic, social, political and geographical elements, and any particular points in time, is always influenced by many other factors" (Helman, 2007, p.4). Cultural variation also affects the concept of ill-health, medication and health-related subjects. Arthur Kleinman (1980) found that "Cultural variation may exert a definable influence on rate and courses of affective sickness, and also on the nature and relative efficacy of indigenous healing approaches to affective disorders" (Kleinman, 1980, P.176). The Magars are also one of the distinct ethnic groups among many

ethnic/caste groups of Nepal, and they belong to indigenous people (GoN-NFDIN, 2063BS). They have their own culture and social system. Based on this, it is needed to have an in-depth study regarding the health issues of the Magars and to acknowledge the subject of the health care system.

1.1.2 Understanding of Ill-health and Medication Practice

Creation of the concept on ill-health, health-seeking behaviour varies as per the socio-cultural context of individual, group or ethnicity. Kleinman (1980) has reported that, "the social and cultural context of the individual plays role in the primary development of effect and affective disease, as well as in the secondary cultural elaboration of effective behaviour and affective illness" (Kleinman, 1980, p.171). Suicide is considered as a mental disorder in a bio-medical model, but Durkheim (1951) argues that individual doing suicide is a social and cultural phenomenon which leads to suicide. Parsons (1951), introduced a sick role in his book 'social system' based on the functionalist perspective of society; "where, social systems were linked to system of personality and culture to form a basis for social order" (Cockerham, 2012, p. 170). Furthermore, "the sick role in relation to social system within which that person lived" (Cockerham, 2012, p. 170). This sick role theory illustrated that illness and sickness behaviours deviate as per the society and culture where an individual lived.

In Medical sociology and anthropology, "the term *disease* has been characterized as an adverse physical state, consisting of a physiological dysfunction within an individual; an *illness* as a subject state, pertaining to an individual's psychological awareness of having a disease and usually causing that person to modify his or her behaviour; and *sickness* as a social state, signifying an impaired social role for those who are ill" (Cockerham, 2012, p. 167). When an individual falls in illness, he or she communicates with friends, relatives, community members or available persons and this "social networks are frequently utilized in decision-making about seeking medical help" (Gabe, Bury and Elston, 2004, p.67). Similarly, medication practices are also based on socio-cultural context because cultural values, beliefs, political power and availability of health care, socio-economic situations, a consciousness of individual and ethnic or community towards illness and health care facilities shaped the individual's medication seeking behaviour.

1.1.3 Health Care Services

In Nepal, health services are medical pluralistic in nature (Subedi, 2001; Harper, 2014; Helmen 2007). Although domination in health care services is a western bio-medical model

in Nepal, there is existence of shamanism, ethno-medicine, worshipping ancestors and nature, worshipping or preying in shrines, *Ayurveda*, *Unani system*, *Accupressure*, *Amchi*, *Homeopathy*, *Naturopathy*, *Yoga*, *meditation* and so on. The government and private sectors are spending their money on bio-medical model of health care and business. The government of Nepal allocates little budget for *Ayurveda* health care centres. Even though the government has not allocated a budget and planned any programs for faith healers, shamanism, shrine and nature worshipping, uses of herbs and shrubs, ethno-medical practices (i.e. the traditional health care practices of Nepalese society) are still found in the Nepalese communities. Indigenous people, the Magars are also members of this Nepalese society; therefore they could have influenced from this medical pluralism in their culture.

In Nepal, the distribution of health service and facilities are diverse and unequal based on political and bureaucratic power or discourse. The political leaders and high-level government personnel and their relatives have easy access to grab those health services grants for the treatment within Nepal or abroad. Nepal Army Hospital and Police Hospital were established presently serving army or police personnel and their families which continue even after their retirement. Similarly, civil servants of Nepal, governmental personnel and their families also have their hospital at the central level and get a 50% discount in treatment within service time or after retirement. Furthermore, most of the advanced hospitals and health facilities are only in the centre level and district or zone/state headquarters. Rural areas are lacking proper health care facilities. However, the government has been providing free medicine from health posts in few numbers, and some beds are allocated for the poor in hospitals; but a power or link is needed to gain benefit from that. Most of the government-owned or government-funded health institutions are not in up-to-date. The Magars have been living in a remote area, and their culture and language are not recognized or understood in the national mainstream. Their representation in the nation is below in comparison of population proportion of Nepal. In existing health services and policies, there are not any safeguards in accordance with culture and society. It helps in the creation of inequality.

1.1.4 Overview on Magar Culture and Society

The Magars of Nepal have a great role in the construction of modern Nepal. They were good warriors, agriculturists, mine and mineral experts, woodcrafts and so on. They became one of the prominent role players in the process of unifying Nepal led by the King Prithvi Narayan Shah and his successors. About Nepal's unification process, Regmi (2007) writes, "the Gorkhali fighters included Khasas and Magars in General" (Regmi, 2007, p. 46). It shows

that the Magars were playing a vital role in Nepal's unification process. In such a way, western scholars have been stating Magars –a warrior ethnic group (Kirkpatrick, 2007; Hamilton, 2007; Wright, 2007; Vansittart, 1906; Hodgson, 1874; Northey, 1998; Caplan, 2009; and so on). Besides, the Magars had and have active participation in the Nepalese revolution and changes. The first Martyr of Nepal, Lakhana Thapa Magar was from Magar community who fought against the autocratic *Rana* regime and showed enlightenment for democratic movements. Similarly, the Magars have a history of their bravery and sacrifices in the unification of Nepal, for democratic revolution, peoples' war and republic revolutions.

The Magars are indigenous peoples of Nepal and are categorized under the disadvantaged group (GoN-NFDIN, 2063 BS). In Magar village, senior adults of Magars themselves call themselves Manggar /*mʌŋgʌr*/. Similarly, in eastern Nepal, Sikkim and other parts of India, they are pronounced as "Manggar /*mʌŋgʌr*" (Chemjong, 1967). Furthermore, Tamangs, Gurungs and some other Tibeto-Burman language speakers call Māngar /*mʌŋgʌr*/. However, in Nepal, they are officially documented as a Magar /*mʌgʌr*/. William J. Kirkpatrick (1793) has written as, "Mangur tribes" (Kirkpatrick, 2007, p.123) for Magars. Hence, in the Tibeto-Burman language, Magars' original name could be *Māngar* or *Mangar* and 'Magar /*mʌgʌr*' word, could be influenced of Indo-European language.

The Magars have Mongoloid physical feature with well proportioned facial contours and yellowish colour (Bista, 2004, p.67), military tribes (Hamilton 2007; Wright, 2007, p. 26; Vansittart, 1906; Northey, 1998, p. 8) and tartar race's (Vansittart, 1906, p.77). Similarly, Magars are included in the "Mongol-Kirant" genealogy (Sharma, 2067 BS, pp.43-45 and 244). And Shiwakoti (2074 BS) argued that until the 12th Century they were called *Kirant*; after following Hinduism Magars separated from the *Kirat* descendent. The Magars have more than a thousand sub-clans but there is no caste hierarchy system (Shiwakoti, 2074 BS p.48). The Magars have Mongoloid feature (which is also called an Asian face) and Kirat descents, however, there could be mixed with other races and became today's Magars. Because Nepali society was formed by various and several times inter-mixed with different races and ethnic groups who migrated in this territory from different places of the world (Sharma 2067 BS; Pokharel, 2055 BS) in the past time of history. The Magars have their own ancestral mother tongue and this belongs to Tibeto-Burman family and consists of at least three mutually unintelligible dialects (Bista, 2004, p.67), and these dialect or languages are called Magar Dhut, Magar Kham/Pang, and Magar Kaike (Thapamagar, 2066 BS; Budhamagar, 2011; Chidi 2071 BS, p. 40; Sinjali, 2072BS, p.3).

Settlement of the Magars is western Nepal, especially, Trishuli river west to east of Karnali river (Gandak river beds and hills) where the Magars have a dense population and also scattered all over the country (CBS, Feb 2014). About the habitat of the Magars, Nepali Scholar Dr. Dilli Raman Regmi (2007) shows as, "the Magars are a tribe of people living mostly in the basin of the Gandak, but they are also scattered through-out central Nepal. It is also said that most of the Magars deserted Gorkha to take refuge in Nepal" (Regmi, 2007, p.46). However, in Sikkim and some parts of India, Bangladesh and Bhutan; there are also Magars as aborigines of that land. After Gurkha Army custom and Nepalese connection with a foreign country; the Magars are being scattered and settled all over the world.

Culturally, the Magars are animistic or nature worshiper in tradition (Baralmagar, 2063BS, p.50; Shris, 2073BS, p.249; Pun & Ghartimagar, 2071BS, p.201), they worship natural objects like big trees, stones, hills and mountains, pass between two mountain (Bhanjyang), river, water sources, cattle, birds and other natural objects naming them as different god and goddess such as *Onghyā*, *Sirung*, *Chandi*, *Gaidu*, *Yaunāt*, *Bāyu* and so on. In contrast, northern Magars are influenced from Buddhism (Fisher, 1986) and southern Magars are influenced from Hindu religion (Vansittart, 1906) because "majority of Magars are in close contact with Brahmans and Chhetris" (Bista 2004, p.70) and co-settling. Furthermore, the Hindu priest was employed at Gurkha Rifles of (GR) of British India (East India Company), independent India and British's Gurkha Rifles (GR). The Magars have the tradition of joining Gurkha Rifles (GR) as *lahure* culture. In this way, Gurkhas soldiers brought Hindu culture and Hindu god, goddess statues in their villages too. Therefore, there was easily diffusion of Hindu culture among the Magars, although they were animists or worshipers of nature. Shepherd (1982, p.45) also observed cultural and lingual changes among the Magars at Yangchok, Tanahu and Arkhala, Nawalparasi Districts. In socio-cultural changes, indigenous knowledge and practices towards health, illness and medication might have disappeared or changed. In fact, there are also found myths of ill-health concepts (knowledge, Attitude & Practice) in birth, marriage and death rituals. In the Magar society, there is a belief of *lama*, *dhami*, *bannaini*, *rakchhes*, ghost, witch & witchcraft and other spiritual beliefs even today. There is a culture of *Gwa Garanke* (a promise to perform a sacrifice to the god or goddess for the fulfilment of one's wish) and give sacrifice to worship in a favourable time to get relief from illness and prevention of disease till present (Sinjali, 2067 BS, p. 82).

In addition, the Magars had their own traditional dress of Magar. The male Magars wear *Bhoto*, *Kachhad*, *Gado/Bhangra*, *Dhakatopi* (Nepali cap) whereas *Gunyu*, *Choli*, *Matha*

(*Patuka*), *ghalek*, *Ghorpyak* with a small sickle costume for females. Their traditional dress shows their ecological and environmental adaptation and indigenous knowledge and skills. Marriage practices in the Magar community are found being cross-cousin (*phupu chela-Mama cheli*) marriage. Likewise, *Sorathi* (*Maruni/Karhangnacha*), *Ghantu*, *Jhamre*, *Salaijo*, *Rodi*, *Thado Bhaka*, *Jiwai-Mama*, *Kaurha*, and many more such folk dances and songs are found among the Magars of Gandak basin. The folk dances and songs such as *Paiseru*, *Bhumya*, *Saranggya Syai*, *Jyomare* (like *Jiwai-Mama*), *Hapare* are found in Rukum, Rolpa and western Banglung. Similarly, *Hurra* folk dance is found among the eastern Magars. Additionally, the Magars used to practice "*Bheja*" social system, a traditional institution to conduct the Magar society and provide justice in the villages. However, it has been changed and is disappearing among the Magars with changes in the Nepalese political system.

In fact, the Magars have their own culture, language, indigenous knowledge and technology, world views in their Magar settlements. Being a perception of ill-health, well-being, health-seeking behaviours socio-cultural phenomena, the Magar socio-cultural context differs in the perception of ill-health and medication practices with the mainstream culture of the nation. Therefore, it is necessary for an in-depth study about the ill-health and medication practices rooted in the socio-cultural background of the Magars.

1.2 Statement of Problem

The early work on studying ethnic groups of Nepal was started by some western scholars on the occasion of their Nepal mission after the unification of Nepal. About the Magars, Kirkpatrick (2007) noted some information based on his Nepal mission of 1793. Subsequently, Hamilton (2007) mentioned some information about the Magars based on his Nepal mission of 1803/04. Their intention was not the complete study of the Magars, indigenous knowledge and healthcare system. Similarly, Hodgson (1874), Daniel Wright (1877), Oldfield (1880) studied Nepal and explored different aspects of the Magars whereas the socio-cultural perceptions towards ill-health and medication practices, indigenous knowledge were not included. In the same way, Vansittart (1906) studied the Gurkha soldier's ethnicity and socio-cultural aspects where some aspects of Magars had been mentioned. Further, Levi (1905) stated a few accounts about the Magars. However, those publications were not related to health and medication practices among the Magars and indigenous knowledge.

After the political changes in 1950 in Nepal, Nepal was open to foreigners to study and research. So studying about the Magars, Hitchcock (1965) studied the Magars of Banyan hill,

Jiro (1974) did about northern Magars, Waters (1975) studied Magars of Rukum and Rolpa districts, Molnar (1981) studied the Magars of Rukum and Rolpa, Shepherd (1982) had researched about the Magars of Tanahun and Nawalparasi districts, Fisher (1986) did about Dolpali Magars and their trade. These scholars explored more account of Magars than previous publications; but, particular subjects on ill-health and medication practices were not explored.

In such a way, from Nepali scholar Regmi (1966), Bista (1967), Chemjong (1967), Sharma (2039BS), Gurung (1980), Gurung (1999), Rai-Rupabung (2064BS), Gurung (2067BS) and some others scholars have stated some aspects of the Magars in their literature. Similarly, within the Magar community, Baralmagar (2050 BS), Thapamagar (2059 BS), Budhamaagar (1992), Ghartimagar (2053 BS), Magar (2013) and other scholars studied about the Magars but they have not attempted to explore the concept of ill-health and medication practices. Furthermore, Harper (2014), Gartoula (1998 & 2012), Subedi (2001 & 2003), Miller (1997), Sagant (1996), Gautam and Bhattarai (eds.) (2062 BS), Adam (1998), Dixit (2005), Hitchcock, J. T. & Rex L. Jones (eds.) (1996), Kristvik, (1999) and other scholars researched about the public health, Medical Sociology/Anthropology and health care within Nepal, but these were not related with indigenous peoples Magars. Therefore, it is required to conduct among the indigenous people Magars to explore their indigenous knowledge, ill-health and healings, medical pluralism and medication practices in their socio-cultural context and understand them.

The Magars are indigenous peoples of Nepal (GoN-NFDIN, 2063 BS). They have a unique culture, language, social system and worldviews, distinct from others. In contrast, their own perception and lenses about health and illness, health-seeking behaviours from their own lenses have not been studied yet. "Cultural background has an important influence on many aspects of people's lives, including their beliefs, behaviour, perceptions, emotions, language, religions, rituals, family structure, diet, dress, body image, concepts of space and of time, and attitudes to illness, pain and other forms of misfortune- all of which may have important implications for health and health care" (Helman 2007, p.3). Therefore, the study of indigenous knowledge and practices on health and illness, healing may be beneficial to the health care system, research works and knowledge building process. Furthermore, Nepal has a heritage of diversity in ethnicity, culture, language, geography, ecology and settlements. In this diverse setting, concepts towards health & illness, health-seeking behaviours become different according to their own cultural and social settings. And the difference in knowledge

and practices could be increased from settlement ecology and mode of production, availability of health facilities, religions, consciousness of the individuals, lifestyle and living way, ethnic worldview or philosophy and lenses, media and contact with the outer world.

Although Nepal is rich in the heritage of ethnic diversity, culture and languages, customs and traditions, indigenous knowledge and skills, natural beauty and natural resource, it is far behind as compared to other developed countries of the world in terms of conservation and development of such heritages, human development index (HDI). In this heritage of diversity, certain groups of people are behind the mainstream in the proportion of population structure, especially women, indigenous peoples, *Dalits*, people of rural areas and so on. From such inequalities and historical discrimination, there is a deep-rooted vicious circle of poverty or disorders. Some superstitions or traditional bad practices, cruel practices and beliefs like as *boksi*, *chhaupadi* etc. have been prevailing even at present time. The good practices or beneficial knowledge and skills of indigenous peoples or locals are not explored and highlighted. "The content of the health care systems varies from society to society (depend on social, cultural, historical and economical factors), a range of healing traditions in common to all" (Gabe, Bury and Elston, 2004, pp.183-184). Furthermore, in health problems individuals and societies respond according to their culture, norms and values (Cockerham, 2012, p.1). So, in socio-cultural diversities, the perceptions on health, illness and healings, and indigenous practices on health become distinct from each other. Though government and development agencies are allocating sufficient budgets to improve Nepalese health status, the achievement is always lacking. In this national situation, studies on perceptions of ill-health and medication practice in socio-cultural background of the Magars helps to understand lacking on health care system from the medical sociological perspective and uplift health status in society.

In such a way; the culture and language, social systems, customary laws and practices, indigenous knowledge and skills of the Magars are surviving under the pressure of national mainstream culture and discourse, Indian culture and discourses, globalization, modernization, westernization as well as development of media, information and communication technology (ICT), modern education, haphazard development and lacking safeguards, consumerism and economic liberalization and socio-cultural hegemony of powerful societies (Yonjan-Tamang, 2012; Pun and Ghartimagar 2071BS; Sinjali 2071; Shris, 2073BS). The consequence has changed towards disappearance in heritages which were protected by the Magars. However, the changing process is normal and continues. No

research has ever been attempted to analyze and explore health, illness perceptions and medication practices in their socio-cultural background of the Magars. This social phenomenon had not been rigors dissected and which was seen from the survey of the literature. For this reason, it is essential to conduct such a study to identify their health problems, indigenous concepts and medication practices in their socio-cultural background.

1.3 Research Questions

To fulfil the above-mentioned research problems, the following research questions are raised to complete the study; and the dissertation is prepared based on these research questions:

- (1) In what ways do Magars define 'health and illness' on the basis of their culture, indigenous knowledge and realities of life today?
- (2) How have the Magars been adopting and following the preventive and curative methods/practices over the years (past and present)?
- (3) Why 'traditional and modern' concepts and practices in relation to health, illness and healing are prevalent among the Magars?

1.4 Objectives of the Study

The general objective of this study is to explore the concept of health, illness and medication practices among the underprivileged indigenous peoples Magars in their socio-cultural context, acquired on day-to-day livelihood. The specific objectives were:

- (1) To describe existing health care and medication practices among the Magars,
- (2) To explore perceptions of Magars towards health and illness in their socio-cultural background, and
- (3) To analyze changing health perceptions and medication practices among the Magars.

1.5 Significance of the Study

Nepal has diversities in ethnicity, language, culture and geographical settings. The Magars are one of the indigenous peoples or groups in Nepal. The "cultural and biological differences contribute to ethnic inequalities in health" (Gabe, Bury and Elston, 2004, p.17). This study explores the ill-health concepts and medication practices of the Magars from the medical sociological perspective. In addition, the disadvantaged ethnic peoples are "the outcome of a long history of institutional discrimination that has produced the current level of disadvantage" (Gabe,

Bury and Elston, 2004, p.18). And this research provides the historical aspects of the Magars in the subject of indigenous knowledge about ill-health, medication practices in their socio-cultural context in sociology discipline. In such a way, "research is equally important for social scientists in studying social relationships and in seeking answers to various social problems" (Kothari and Garg, 2015, p.6). This study has explored the problems faced by the Magars in health care services and research has identified a relationship between indigenous peoples Magars' lens in the concept of ill-health and medication in their own socio-culture background.

The western scholars, the Nepalese scholars and the Magar scholars who had to explore the Magars and their issues, they have not attempted to describe the perception of ill-health and medication practices among the Magars. Furthermore, Harper (2014), Gartoulla (1998 & 2012), Subedi (2001 & 2003), Miller (1997), Sagant (1996), Gautam and Bhattarai (eds.) (2062 BS), Adam (1998), Dixit (2005), Hitchcock, J. T. & Rex L. Jones (eds.) (1996), Kristvik, (1999) and other scholars who stated about health care, public health, medical sociology and anthropology perspectives but they have not focused in indigenous peoples (i.e. Magars). Thus this research is focused on health sociology and medical sociological studies of the local Magars.

In the same way, although Nepal has diversity in terms of socio-culture, ethnicity, language, geography and social ecology, there are no sufficient studies to address the problems. The Magars created their culture, language, social norm and values, belief and worldviews from immemorial time by adapting the natural environment, mode of production. Every culture has its traditional healing systems. In Nepal, shamans (*Lama/Jhankri*), priests are traditional healers; and *boksi* (witchcraft), *ghost*, *rakchhes*, *bayu*, *sansari mai*, *devi*, *deurali*, *sirung*, *onghya*, *lago-bhago (dokh)* and so on are traditional causations of illness. In Magar culture, using local herbs and shrubs for healing, folk dances for healing, faith healing, worshipping, promising (Bhokal) and so on are traditional healing practices.

On the other hand, after Anglo-Nepal war and *Sugauli treaty*; the Magars were compelled to join in British ruled India's Gurkha Rifles for employment due to contemporary national politics. They fought World War-I & II and several wars for the British and India. From India's independence, they are divided into India, the British, and Singapore for military services. Later on, foreign employment increased into Indian cities and foreign countries in other sectors and it developed into a culture and fashion among the Magars. This nature of employments and remittance economic sources lead to school drop-outs and low-education level, low level of critical thinking and awareness, low representation in the national mainstream, loss of scientific indigenous knowledge and practices, early age marriage, massive migration and risk of communicable illness including STI and HIV/AIDS in the Magar society. In this situation, the research has explored the problems from medical sociological perspectives which help to understand indigenous knowledge and practice, a situation of ill-health awareness, problems to further researchers and policymakers. Finally,

the value added of this research is the local perception of ill-health and medication practices of the Magars based on their own culture and social setting through a sociological eye.

1.6 Operational Definitions

Definitions of conceptual terminologies (operational definition) which are used in the dissertation to describe of the findings of the study are as follows:

Culture: "That complex whole which includes, belief, art, morals, law, custom and any other capabilities and habits acquired by man as a member of society" (Tylor, 1871).

Disease: A bio-medical concept; an adverse in physical state or physiological dysfunction or something wrong in bodily function of an individual.

Ethnic group: Group of people which having their own culture, language, common origin and shared history which is different from others. Ethnicity is part of the social system of stratification.

Health: In general absences of disease or infirmity and having well-being; but, World Health Organization has defined as, "health is a state of complete physical, mental and social wellbeing and not merely an absence of disease or infirmity" (WHO 1948); which carries broad aspects of human life. Therefore, "Health is not simply biology but involves a number of factors that are cultural, political, economic, and—specially—social in nature" (Cockerham, 2012, p.2).

Healing: Healing is the process of making or becoming sound or healthy again.

Illness: Individual's perception and behaviours into the response of disease and it is a subjective state. It is also the impacts of diseases on the individual's psychological environment and awareness to seek health care.

Indigenous: Peoples (or knowledge) naturally existing in a place or country rather than arriving from another place

Lama: Lama/Lāmā is a traditional healer, priest and philosopher of ancient Magar society which is also known as a shaman.

Lay Understanding: Lay understanding or perception of health is perception regarding health and health-related subject by a layperson; and that is based on their own culture, society and the social system.

Medical Sociology: Branch of sociology, sometimes referred to as health sociology, is the study of the social causes and consequences of health and illness.

Medical Anthropology: Medical Anthropology is a subfield of anthropology that draws upon social, cultural, biological, and linguistic anthropology to better understand

those factors which influence health and well being (broadly defined), the experience and distribution of illness, the prevention and treatment of sickness, healing processes, the social relations of therapy management, and the cultural importance and utilization of pluralistic medical systems.

Magar: An ethnic group of Nepal among the 125 ethnic groups, they share the third-largest population and have distinct culture and language, social ways. Although being scattered all over the country, they are densely populated in Gandaki river basin and hills.

Magar Language: Ancestral language of Magars with distinctively in three dialects: (1) Magar Kaike (2) Magar Kham (3) Magar Dhut. In this research, I have talked about Magar Dhut or Magar Kura.

Magarāt: Ancient habitat of Magars which lies in between Karnali river east and Trisuli river, the western and hilly area.

Sickness: Sickness is a social state of an ill-person or individuals and refers to impairment in social role or dysfunction of a social state.

Society: Society is a large group of people who live together in an organized way, making decisions about how to do things and sharing the work that needs to be done.

1.7 Organization of the Research work

This dissertation consists of ten chapters, each with sub-topics. The chapters are mentioned briefly as follows:

Chapter-One includes introductory and background chapter. The chapter describes the background of the study, health and society, the concept of illness and medication practices, statement of problems, research questions and objectives, the significance of the study, operational definition and organization of the dissertation.

Chapter-two presents literature review. The chapter deal with literature reviews in sociology and health, Magars, Culture, health and society, health care services, Medical sociology and anthropology in Nepal and theoretical considerations.

Chapter-Three includes research methodology. The chapter describes the philosophical foundation of research, theoretical perspective and conceptual framework, research approach, research design, research method, sampling design, nature and sources of data, research instrument and data collection tools, variable of the research, reliability and validity, method of data analysis and interpretation and ethical considerations.

Chapter-Four portrays the settings and characteristics of the study population. The chapter has described the background Syangja district, the study area surrounding Tamkikot hill and the characteristics of study populations.

Chapter-Five presents the Magars and their socio-cultural background which was obtained from qualitative data. The chapter describes institution and social relationships, life cycle rituals and health, feast and festivals, folk song and dances, deities and worshipping among the Magars.

Chapter-Six describes the health care system, facilities and policies of Nepal, socioeconomic status, socio-economic impacts and livelihood of Magars, and indigenous knowledge towards health, illness and medication practices.

Chapter-Seven represents the findings and analysis of beliefs, perceptions and concepts regarding health, illness and medication practices. The chapter describes beliefs on spiritual causes of illness, perceptions towards micro-organism, communicable illness and non-communicable illness, reproductive health and HIV/AIDS, traditional health and bio-medicines, nutrition, occupational health, mental health. It also deals with health concepts in their socio-cultural backgrounds from quantitatively, knowledge about health institutions and health rights.

Chapter-Eight represents the findings and analysis on achieving health and wellbeing, practices in ill-health and healings obtained from the quantitative data. It also deals with practices on transforming indigenous knowledge and skills, medicine storing practice, self-medication practice, practices maternal and child health, health-seeking practices.

Chapter-Nine represents changing attitudes on health and medication practices. It also deals with changing patterns of perception, concepts and knowledge about health, illness and healing practices.

Chapter-Ten is a summary and conclusion chapter. The chapter deals with the summary, conclusion, limitation of the study, the recommendation for future research, contributions of the study to the discipline of sociology.

Finally, the references and annexes/appendixes are attached which includes References; Magar Population Distribution; Permission letter of Nepal Health Research Council; Ethnic wise population of Syangja; Health care provision in constitution of Nepal; Health policy of Nepal; Nepal stands in term of achieving the MDGs; Organogram of the department of health services and functions; Medical colleges and Teaching hospitals of Nepal; Indigenous knowledge regarding health, illness and healings; Questionnaires; Checklist; List of key informants; and Glossory.

CHAPTER - TWO

LITERATURE REVIEW

In this chapter, a review of available relevant literature related to health, illness, medications and Magars is reviewed. The review is divided into sections and sub-sections according to the contextual subject matters.

2.1 Overview of Sociology and Health

In every society, health, illness and healings are some of the most common social phenomena. In this chapter, an introductory review of available relevant literatures related to social health, sociology of health, medical sociology, medical anthropology, public health, and epidemiology is attempted.

2.1.1 Sociology, Health and Illness

Health and well-being are the main concerns of an individual and society. Every culture and social system tends to have their own belief and practices for good health and medication practices to cure illness. "Health is influenced by a wide range of social circumstances and public policies, and not just by access to health care and traditional health-sector policies" (Anand, Peter and Sen, 2004, p.2). Besides this, "Health is a common theme in most cultures. In fact, all communities have their concepts of health, as part of their culture" (Park 2005, p.12). "From a sociological point of view, disease is considered as a social phenomenon, occurring in all societies and defined and fought in terms of the particular cultural forces prevalent in the society" (Park, 2005, p.29). And "sociology has an important role in providing a counterpoint to the predominant biological and medical approaches to health and illness" (Olafsdottir, 2013, p.56).

In medical terms "health is the absence of disease, yet this is an impoverished understanding of good health" (Bradby, 2009, p.58). "There is no single, all-purpose definition of health that fits all Circumstances, but there are many concepts such as health as normality, the absence of disease, or the ability to function" (Blaxter, 2010; Cockerham, 2012, p.7). The World Health Organization (WHO 1948) defined it as, "health is a state of complete physical, mental and social wellbeing and not merely an absence of disease or infirmity" (WHO 1948, cited by Park 2005, p.13). However, in recent years, this statement has been amplified to

include the ability to lead a “socially and economically productive life” (Park, 2005, p.13). In addition, "health is not simply biology but involves a number of factors that are cultural, political, economic, and—specially—social in nature" (Cockerham, 2012, p.2). Thomas Mckeown (1979) points out that "the personal experience that feeling of well-being are more than the perceived absence of disease and disability. Many influences—social, religious, economic, personal, and medical—contribute to such feelings" (Cockerham, 2012, p.7). Further he argues "the role of medicine in this situation is the prevention of illness and premature death, as well as the care of the sick and disabled. McKeown concludes that medicine's task is not to create happiness but to remove a major source of unhappiness—disease and disability—from peoples' live" (Cockerham, 2012, p.7).

The lay understanding (a lay person’s understanding) of health is based on their own culture and society or social system. The "lay conception of health has been the subject of sustained research. The research has explored how people think about their own and their family's health, and how their thinking contradicts medical models" (Bardby, 2009, p.58). "There has been growing recognition of the influential role of class, gender, and ethnicity on the subjective experience of health and heal care" (Bardby, 2009, p.58). In such a way Helman (2007) has described, that different cultures, occupations and social situations differing in lay person's concept in health, illness, body anatomy and physiology and healing. He has given the example of 'the body as a machine' concept in western society which is can be replaced as the machine in healing (Helman, 2007).

About the illness, disease, sickness of health in sociological concepts, William C. Cockerham (2012) has mentioned as;

"In Medical sociology, the term *disease* has been characterized as an adverse physical state, consisting of a physiological dysfunction within an individual: an *illness* as a subjective state, pertaining to an individual's psychological awareness of having a disease and usually causing that person to modify his or her behaviour; and *sickness* as a social state, signifying an impaired social role for those who are ill." (Cockerham, 2012, p.167)

Similarly, Susser and Waston (1971) stated as, "disease is a physiological/psychological dysfunction; Illness is a subjective state of the person show feels aware of not being well; Sickness is a state of social dysfunction, i.e. role that the individual assumes when ill (sick role)" (Susser and Waston, 1971, Cited by Park, 2005, p.29). K. Park (2005) further described as:

The term "disease" literally means "without ease" (uneasiness)– disease, the opposite of ease –when something is wrong with bodily function. 'Illness refers not only to the presence of a specific disease but also to the individual's perceptions and behaviour in response to the disease, as well as the impact of that disease on the psychological; environment. "sickness" refers to a state of social dysfunction (Park, 2005, p.29).

In addition to this, park (2005) has illustrated the new philosophy of health and stated as follow:

In recent years, we have acquired a new philosophy of health, which may be stated as below: –health is a fundamental human right, – health is the essence of productive life, and not the result of ever-increasing expenditure on medical care, – health is inter sectoral,–health is an integral part of development, – health is central to the concept of quality of life, – health involves individuals, state and international responsibility, – health and its maintenance is a major social investment,–health is world-wide social goal (Park, 2005, p.13).

Furthermore, "different set of issues–politics, power, and stereotype–and of causal factors, such as how the media fostered fears and how popular beliefs about the meaning of illness bred bigotry against ill person" (Weitz, 2007, p.7).

In addition, Blaxter (2010) mentioned that "Several studies suggest that laypersons generally conceive of health as the relative absence of the symptoms of illness, a feeling of physical and mental equilibrium or well being, being able to carry out one's daily tasks, or some combination of the preceding (Blaxter 2010, cited by Cockerham, 2012, p.159). Further, Cockerham (2012) described, "Conversely, to be ill means the presence of symptoms, feeling bad and in a state of disequilibrium, and functional incapacitation (not being able to carry out ones' usual activities)" and he has added, "Thus, what laypersons recognize as illness is in part deviance from a standard of normality established by common sense and everyday experience" (Cockerham, 2012, p.159).

About the social perspective regarding health and illness Weitz (2007) illustrated as, "The topics researched by the sociologist of health, illness, and health care overlap in many ways with those most clearly differentiates sociologists from these other researchers is the sociological perspective studied by health psychologists, medical anthropologists, public health workers, and others" (p.5) and "In sum, the sociological perspective shifts our focus from individual to social groups and institutions. One effect of this shift is to highlight the role of power. Power refers to the ability to get others to do what one wants, whether

willingly or unwillingly" (Weitz, 2007.p.7). In such a way, Weitz (2007) further described the study of health and illness from a sociological perspective as:

First, sociologists can study how social forces promote health and illness and why some social groups suffer more illness than others do. Similarly, sociologists can study how historical changes in patterns of social life can explain changes in patterns of illness. Second, instead of studying broad patterns of illness, a sociologist can study the experience of those who live with illness on a day-to-day basis—exploring, how illness affects individuals' sense of identity, relationships with family or ideas about what causes illness. Third, sociologists study how social factors affect health care providers. Some sociologists have analyzed how the status and power of different occupations have shifted over time others have investigated how power affects interactions between health care occupations. .. interaction between health care workers and patients. And, finally, sociologists can analyze the health care system as a whole (Weitz, 2007, pp.4-5).

"Sociology can relate to health and illness in two different ways" (Bury 1997:4, cited by Gabe, Bury and Elston, 2004, p.ix). Gabe, Bury and Elston, (2004) illustrated, "On the one hand, a sociological perspective can be applied to the experience and social distribution of health and health disorder and to the institutions through which care and cure are provided" (p.ix). Further they stated, "On the other hand, the sociological study of health and illness and institutions of health care can stand alongside analysis of other significant social experiences and institutions, as a means of understanding the society under study" (Gabe, Bury and Elston, 2004, p.ix). In such a way, "health is also one of the important variables of capability inequality. Good health is a necessary precondition of better living standards of people. Thus, health status also creates inequality among people" (Gautam, 2013, p.41). Furthermore, "Sociologists of health and illness explore the role of social, cultural and economic division in the experience of health and illness, with class, age, gender, sexuality, impairments and, increasingly, race, culture and ethnicity being crucial dimensions of analysis" (Ahmad and Bradby, 2008, p.1)

2.1.2 Medical Sociology

Medical sociology is a branch of sociology, which is closely related to sociology and health science. Sometimes, medical sociology is referred to as health sociology and "Medical sociology focused on the social causes and consequences of health and illness" (Cockerham, 2012, p.1). In such a way, medical sociology is concerned with the "social facets of health

and illness, the social function of health institutions, and organizations, the relationship of health care delivery to other social systems, and social behaviour of health personnel and those people who are consumers of the health care" (Gartoulla, 2008, pp.216-7). "Medical sociology's interests are in the structural organization of health services in society, and how they relate to other social structures and how these contribute to or detract from health" (Goldie, 1995, Cited by Maclachlan, 2006, p.3). Maclachlan, (2006) mentioned as, "the tradition within medical sociology has, however, been to focus on social structure in western societies. Although, in principle the social structure of any cultural group may be of interest to medical sociologists". Further, he clarified, "Another way of construing what medical sociology is about is that it is interested in the *culture of healthcare* within a society" (Maclachlan, 2006, p.3). Similarly, Bradby (2009) mentioned as:

Medical sociology is the study of the structural and cultural feature of medicine as an institution, a profession and a discipline: scholarship in this area is also termed the 'sociology of health and illness' to underline that understanding of health and illness in society are no confined to medicine, but encompass a broader field of inquiry (Bradby, 2009, p.1).

Similarly, White (2006) defined medical sociology terminology in his dictionary 'The Sage Dictionary of Health and Society' as:

Medical sociology: A term first used by Elizabeth Blackwell to highlight the intersection between social issues such as sexuality and religion and medicine. Following the work of Parsons in the 1950s, medical sociology became the academic discipline assisting professional medicine in pursuit of understanding patients and their actions, particularly their compliance or non-compliance with medical orders, and help-seeking behaviour (White 2006, p.142).

Cockerham (2012) stated as, "Medical sociology brings sociological perspectives, theories, and methods to the study of health, illness and medical practices" (p.1) and further he described as:

Areas of investigation include the social facets of health and disease, the social behaviour of health care personnel and their patients, the social functions of health organizations and institutions, the social patterns of the utilization of health services, and relationship of health care delivery systems to others social institutions, and social policies toward health. What makes medical sociology important is the critical role social factors play in determining or influencing the health of individuals, groups, and

the larger society. Social conditions and situations not only promote and, in some cases, cause the possibility of illness and disability, but also enhance prospects for disease prevention and health maintenance (Cockerham, 2012, p.1).

Medical sociology "is also a theoretically orientated field, committed to explaining large-scale social transformations and their implications, as well as interactions in everyday settings, as these are expressed in health and illness" (Gabe, Bury and Elston, 2004, p.ix) and further, "these two aspects of medical sociology have, in a well-worn phrase, been characterized as *sociology in medicine* and *sociology of medicine*" (Straus, 1957; Gabe, Bury and Elston, 2004, p.ix). For these two separate but closely interrelated areas; Cockerham (2012) illustrate, "The sociologist in medicine is one who collaborates directly with physicians and other health personnel in studying the social factors that are relevant to particular health problem". Further, he has clarified, "The work of the sociologist in medicine is intended to be directly applicable to patient care or to the solving of a public health problem. .. can be characterized as *applied research and analysis primarily motivated by a medical problem*, rather than sociological problem" (p.5). On the other hand, sociology of medicine is "deals with such factors as the organization, role relationships, norm, values, and beliefs of medical practice as a form of human behaviour" (p.5). Furthermore, he has clarified, "The sociology of medicine shares the same goals as all other areas of sociology and may consequently be characterized as *research and analysis of the medical environment from a sociological perspective*" (Cockerham, 2012, p.5).

About the development of medical sociology, Cockerham (2012) pointed out, "The earliest works in medical sociology were undertaken by physicians, not by sociologists" (p.2). And further writer described, "The term medical sociology first appeared in 1894, in a medical article by Charles McIntire on importance of social factors in health. ... Other early works included essays in the relationship between medicine and society in 1902 by Elizabeth Blackwell" (Cockerham, 2012, p.2). He has argued, Medical sociology did not begin until the second world-war and after 1940s funding for socio-medical research increased and the development of medical sociology started. "However, as an academic department of sociology grew in 1960s, and developed a strong theoretical orientation, the study of health and illness" (Gabe, Bury and Elston, 2004, p.x), then medical sociology has sprung.

2.1.3 Medical Anthropology, Public Health and Epidemiology

Medical anthropology is sub-disciplines of anthropology and "medical anthropology studies the social and cultural aspects of health and illness" (Pool and Geissler, 2005, p.6). Kevin White (2006) has mentioned medical anthropology terminology in his dictionary 'The Sage Dictionary of Health and Society' as, MEDICAL ANTHROPOLOGY: The study of the beliefs and practices of medicines in other cultures, held up for examination against the taken for granted scientificity of Western **biomedicine**. It is grounded in **socio-biology** and **social Darwinism** (White, 2006, p.139). Cecil G. Helman (2007) illustrated medical anthropology as:

Medical anthropology is about how people in different cultures and social groups explain the causes of ill health, the types of treatment they believe in, and to whom they turn if they do get well. It is also the study of how these beliefs and practices relate to biological, psychological and social changes in the human organism, in both health and disease. It is the study of human suffering, and the steps that people take to explain and relieve that suffering (p.1). Although medical sociology is a branch of social and cultural anthropology, its roots also lie deep within medicine and other natural sciences, for it is concerned with a wide range of biological phenomena, especially in relation to health and disease. As a subject, it therefore lies— sometimes uncomfortably – in the overlap between the social and natural sciences, and draws its insights from both sets of disciplines (Helman, 2007, p.7).

Further, Helman (2007) stated about medical anthropology as, "In foster and Anderson's useful definition it is: A bio-cultural discipline concerned with both the biological and socio-cultural aspects of human behaviour, and particularly with the ways in which the two interacted throughout human history to influence health and disease" (Helman, 2007, p.7). Carol R. Ember, Melvin Ember and Peter N. Peregrine (2015) stated, "Medical anthropologist, who are actively engaged in studying health and illness, are increasingly realizing that biological and social factors need to be considered in we are to reduce human suffering. .. Medical anthropology has developed into a very popular specialty" (p.29) and they further wrote, "Discovering the health-related beliefs, knowledge, and practices of a cultural group—its ethnomedicine—is one of the goals of medical anthropology" (Ember, Ember and Peregrine, 2015, p.30). Similarly, Ritu Prasad Gartoulla (2008) stated, "Medical anthropology is a specialized within the field of cultural anthropology" (p.216). And further he illustrated about medical anthropologist, "interested in bio-cultural—environmental health problems" (p.420). In addition, he clarified about the medical anthropologist's interests as,

"Medical anthropologist, almost by definition ecologically oriented, area concerned with the interrelationships between man's natural and social environment, his behaviour, his diseases, and the ways in which his behaviour and disease have influenced his evolution and culture through feedback process" (Gartoulla, 2008, p.421). In Nepal, Medical anthropologists, specially, foreign anthropologists had shown interest in, especially the idea that indigenous medical system, social institutions, indigenous medical practices, ethno-medicine, cultural perspectives of health and illness and health care (Gartoulla, 1998, pp.16-17).

Public health and epidemiology interrelated subjects with medical sociology and anthropology and social issues regarding health and illness. "Research on the health status of populations and population subgroups has a long history in public health. The relationship between poverty and ill-health, in particular, has been recognized centuries ago" (Anand, Peter and Sen, 2004, p.1). In nowadays "Within the discipline of public health, there is growing appeal to the social sciences and a move towards more interdisciplinary analysis of the social process underlying inequalities in health. This development is labelled the new public health" (Anand, Peter and Sen, 2004, p.2)

"Public health is the art and science of preventing disease promoting health and prolonging life through organized society" (Acheson Report 1987, cited by Carr, Unwin and Pless-Mulloli 2007, p.6) and Public health can be defined as "collective action for sustained population-wide health improvement" (Bonita, and Beaglehole, 2004, Cited by Carr, Unwin and Pless-Mulloli 2007, p.6). Similarly, According to Institute of Medicine (IOM) (1988) described the broad mission of public health in the book 'Future of Public Health' and mentioned as a broad mission of public health is to "fulfil society's interest in assuring conditions in which people can be healthy" (IOM, 1988 p.1, cited by Goldsteen, Goldsteen and Graham, 2011, p.3). And, "Public health is often associated with advocating and providing services for the structurally disadvantaged—those with at least power in their social circumstances" (Goldsteen, Goldsteen and Graham, 2011, p.11). Similarly, "public health shares with the clinical professions a fundamental caring for humanity through concern for health. For these reasons, public health is sometime viewed as a type of clinical profession" (Goldsteen, Goldsteen and Graham, 2011, p.5).

Epidemiology is "the study of the distribution and determinants of health-related states or events in specified populations, and the application of this study to the prevention and control of health problems" (Last, 2001, Cited by Bonita, Beaglehole, and Kjellström, 2006, p.3). "Epidemiology is one of the most important investigative field in the study of health and

disease and is applied through the world to solve the health problem" (Cockerham, 2012, p.23). Similarly, Rothman (2012) stated as, "Epidemiology is much more than applied statistic. It is a scientific discipline with roots in biology, logic, and the philosophy of science. For epidemiologists, statistical method serves as an important tool but not a foundation" (Rothman, 2012, p.vii). However, Epidemiology can be defined as "the study of the distribution and determinants of disease frequency" (Macmahon and Pugh 1970, Cited by Rothman, 2012, p.1) or "the study of the occurrence of illness" (Gaylord, 1979, Cited by Rothman, 2012, p.1).

In public health and social health discipline, "Epidemiologists are concerned not only with death, illness and disability, but also with more positive health states and, most importantly, with the means to improve health. The term, 'disease' encompasses all unfavourable health changes, including injuries and mental health" (Bonita, Beaglehole, and Kjellström, 2006, pp. 2-3). Similarly Cockerham (2012) stated, "The epidemiologist is like a detective, investigating the scene of a crime in which the criminal is a disease or some other form of health menace" (p.45). And "The epidemiologist studies both the origin and distribution of health problems in a population, through the collection of data from many different sources" (p.23). Further he stated, "The next step is the construction of a logical chain of inferences to explain the various factors in a society or segment of that society, that cause a particular health problem to exist" (p.23). Their concern is in "primarily concerned not with individuals but with the health profiles of social aggregates or large populations of people" (p.45). Their important tools are "the ratios used to compute descriptions of mortality, incidence, and prevalence. These rates can be either crude rates or rates reflecting age-specific data sex-specific data, and so on" (Cockerham, 2012, p.45). In epidemiology, "The term *social environment* in epidemiological research refers to actual living conditions, such as poverty or crowding, and also the norms, values, and attitudes that reflect a particular social and cultural context of living" (p.28). Where, "Societies have socially prescribed patterns of behaviour and living arrangements, as well as standards pertaining to the use of water, food and food handling and households and personal hygiene" (Cockerham, 2012, p.28). About the development of the epidemiology and public health Cockerham (2012), mentioned as:

Since its inception in the 1850s, the science of epidemiology has passed through three eras and is now entering a fourth (Susser and Susser 1996a). First was the *sanitary era* of the early nineteenth century, during which the focus of epidemiological work was largely sewage and drainage systems, and the major preventive measure was the

introduction of sanitation programs. Second was the *infectious disease era* that occurred between the late-nineteenth and mid-twentieth century. The principal preventive approach was to break the chain of transmission between the agent and the host. Third is the chronic diseases era that took place in the second half of the twentieth century. Here the focus was on controlling risk factors by modifying lifestyles (i.e. diet, exercise), agents (i.e. cigarette use), or environment (i.e. pollution, passive smoking). According to Susser and Susser (1996b:674), the era of the twenty-first century is that of eco-epidemiology. Preventive measures are multidisciplinary as a scientist from many fields use their techniques to deal with a variety of health problems at the molecular, social behavioural, population, and global levels. Chronic diseases remain the principal threat, but old infectious diseases are re-emerging, along with new ones like the West Nile virus, avian flu and SARS (Cockerham, 2012, pp.28-29).

Helman (2007) has illustrated cultural factors in epidemiology as "both anthropologists and sociologists have made important contributions to the understanding of how these complex factors are related to disease, especially the role of social and cultural context" (p.373). In epidemiology, "part of the continuing surveillance of the community' health involves an awareness of the role of cultural beliefs and behaviours in either improving health or causing disease" (p.174). He also discussed the emergence of cultural epidemiology (p.176) and he has detail explained socio-cultural factors in epidemiology (pp.377-382) and he stated, "In many cases of disease, several cultural factors actually coincide—such as occupation, use of 'chemical comforters' and dietary preferences, some of which may be pathogenic to individuals, while others may be protective" (p.382). Likewise, he also discussed the variations in medical treatment and diagnosis due to the cultural factors (Helman, 2007, p.386).

2.2 Overviews on Magars

2.2. 1 Introduction

Among the 125 ethnic groups of Nepal, the Magars are one of them (CBS, Feb 2014). The name is also uttered as Manggar /*mʌŋgʌr*/ or Māngar /*mʌŋgʌr*/ and the Magar /*mʌgʌr*/ word is the influence of Indo-European language. The Magars are aborigines of Nepal (Hodgson 1874, Part II, p.30; Vansittart, 1906, p.7) and Indigenous Peoples of Nepal (GoN-NFDIN, 2002). They have ancestral mother tongue at least there mutually unintelligible dialects, (Bista, 2004, p. 67) and belong to Tibeto-Burman family (Hodgson, 1874). It was known as Magarkurā (Vansittart, 1906; Northey, 1937, p.190). These dialects are categorized into (a) Athār Magarānt Language (*Khām, Kāike*) and (b) Bāhra Magarānt Language (Baralmagar, 2050BS, p.35) groups. It is also known as *Magar Kāike, Magar Khām/Pāng* and *Magar Dhut*. The mutually unintelligible dialects are due to restriction for conversation among the Magars of *Arghakhanchi, Gulmi, Baglung, Parbat* and *Myagdi* districts (Mountain to Terai) in a historical era (Sinjali, 2072 BS, p.3). The Magars had to maintain their own vernacular tongues, tarter faces (Hodgson 1874, Part II pp.39). Kirkpatrick has published few Magars words (Kirkpatrick 2007, pp.249-251) and Hamilton was deposited Magar vocabulary in the Company library (Hamilton, 1819, pp.25-27). The written literature in Magar language was rare; and few literatures are carried out after 1990s' changes. However, their indigenous knowledge and skills (IKS) regarding Health, illness, wellbeing and healings are preserved in their ancestral mother tongue.

The Magars were counted in Gurkha tribes and they "consist for the most part, of the Khus and Mangur tribes of the Chhetri class; and of the Paure and some other castes of Brahmins; their chieftains are known by appellation of Thurgur" (Kirkpatrick, 2007, p.123). Hamilton found it different than Kshetriya and impure in Hinduism (Hamilton, 2007, p.25). In addition, "until the eighteenth century, the situation was complicated by a fairly fluid boundary between Magars and Khasas" (Whelpton, 2007, p.32). In such a way, Hitchcock, found headman of villages and his followers strongly followed Hinduism; but the public are continuing their tradition. Hitchcock argues that Magar culture is dissemination of southern Indian, Tibetan culture into their traditional culture (Hitchcock, 1966, pp.19-23).

The Magars have historical contribution in unifying Nepal (Regmi 2007; Bista, 2004) and in democratic revolutions. The first Martyr Lakhan Thapamagar was from Magars (Ale, 2012). Similarly, the Majority of fighters were Magars in the Maoist people's war (Whelpton, 2012, p.14, 203) for republic Nepal. They also fought in the I & II world wars for peace through

Gurkha regiments of the British Empire and known as Gurkha braves (Hodgson, 1874; Vansittart, 1906; Wright, 1877; Northey, 1937; Caplan, 2009; Gurung, 1980). The Magars were involved in military service of Genghis Khan, King Prithvi Narayan Shah, British for their empire and Maoist for revolution (Ghartimagar, 2072 BS, p.10).

Furthermore, according to CBS 2011, the literacy rate of Magars is 71.9% (National Level–65.94%). The higher education rate is 1.34% (National level–4.19%). Similarly, primary level education gained Magar population is 73.68% and secondary level is 24.98% (CDSA TU, 2014). The data show that the Magars have a low presence in higher education.

2.2.2 Habitat and Population of Magars

The main habitat of Magars is found in the basin of the Gandak and scattered all over central Nepal (Regmi, 2007, p.47). King Prithvi Narayan Shah's 'Magarāt' lies especially east of Karnali River; low snowing mountain to Chure or Shiwalik Hill (Sharma, 2067 BS, p.243). They spread all over the country including Terai (Bista, 2004, p.67), Baraknagar (2050BS) found Gandaki basin to Bheri basin. The western scholars; Kirkpatrick, (1811), Hamilton (1819) and Wright (1877, p.26) found west from the Kathmandu or Nepal valley. Hodgson, (1991, Part II P.83) found "most of central and lower parts of the mountain, between the Bheri and Marsyangdi rivers". Vansittart (1991, p.83) found, "central and lower parts of the mountains between the Jingrak (Rapti to Gorakhpur) and Marsyangdi rivers". And, Hagen (2070 BS P.48) found Magar villages in Karnali Byansi in between Dhundras and Chhapre. Similarly, Magars are found in "middle mountain belt drained by the Narayani and its tributaries and their shelters have in high mountain pastures or Magar villages on mountain slopes and hilltops" (Hitchcock, 1966, p.1). Besides Nepal, the Magars are found in Sikkim, India, Bangladesh and Bhutan from immemorial time and scatter around the globe through Gurkha regiments, foreign employment and study purposes.

Total population of Magar is 1,887,733 (female 1,013,317 and 874,416 male) where, 1,654,841 live in village and 232,892 Magars live in urban areas. Only 788,530 (female 425,135 and 363,395 males) of the total population of Magars speak Magar language (CBS 2011). District-wise, in *Palpa, Tanahun, Rolpa, Baglung, Pyuthan and Myagdi*, the Magars rank in first place in terms of population. In *Nawalparasi, Rupandehi, Syangja, Surkhet, Rukum, Sindhuli, Salyan, Okhaldhunga and Dolpa*, the Magars are in the second position; and *Gulmi, Dang, Udayapur, Arghakhanchi, Parbat, Mustang, Gorkha and Ramechhap*, they are in the third position (CBS, 2011). The detail population distribution of Magar is presented in Annex-I.

2.2.3 Occupation, Livelihood and Economic Aspects of Magars

Hitchcock (1966) studied Magars of Banyan Hill of Pandhera Thum and he described the Magar's occupation, livelihood and economic aspects. According to him:

"Magars of the Banyan hill are subsistence farmers, and the bulk of their food comes from their two kinds of land. Maize and millet are the main dry-land crops, with wheat barely, and dry rice having only secondary importance. The main crop on the irrigated land is, of course, rice. Only occasionally are the paddy fields used for maize. The deciduous trees that grow everywhere in banyan hill and cluster around houses and line the paths are the source of fodder for livestock" (Hitchcock, 1966, pp.15-16).

Furthermore, he found that "for most families, trading livestock provides extra income even if the sales involve only a few chickens or an occasional buffalo, goat, cow or pig. A few families sell honey or butter"(p.17) for their income. Besides that "The most important non-local source of income in Banyan Hill is army service, a source that is part of long-standing hill tradition". The tradition was started after the Sugauli treaty, "Ever since 1815 Magars, together with Gurungs, Limbus, and Rais formed backbone of the British Gurkhas Brigades. In the two world wars half the Nepalese holders of the Victoria Cross, Britain's highest decoration for bravery, were Magars, one of whom came from a village adjacent to Pandera Thum" (p.17). "In 1947, at the time of India's independence, the regiments of Gurkha Brigade were divided, four remaining with the British and Six going to India". Therefore, "Nepalese soldiers serving with the British today are mainly Borneo, Malaya, and Hong Kong, while those serving with the Indians are guarding India's borders with Pakistan and China". Similarly, he found as "Army service bring additional income to Banyan Hill because there are eight men who served ten years or more in the Gurkha Brigade and now have Pension" (p.17). and pensioners "every year during the winter these men trek to the Indian city of Gorakhpur to collect their money- a trip that may take them, with stops to make purchases, as long as three weeks". He also indicates "even a small pension is a useful asset" and, "pensioner like the Subedar holds a position of weight and respect" (Hitchcock, 1966, p.17).

Additionally, he found hardship and distress for economically poor Magars and he noted that "important local source of income for poorer families is field labor-either for neighboring Brahmins or wealthier Magars". He has given examples such as, "Bir Bahadur, Dev bahadur, Lakshmi Devi's Son and a son of Padam Bahadur all worked regularly as ploughman for Brahman; women like Dubal sing's wives and Jag Maya frequently went to Brahman farms to grind grain or work in the fields" (Hitchcock, 1966, p.17). Besides that for poor families, "the

emergency sources of income are jewellery and land, usually in that order. For marginal families, these are the items with which they meet a father's funeral expenses or keep themselves going through a series of bad years". If someone once falls in debt, then there is difficult to pay from their local income-sources, therefore, he analyzed it as, "Once the downward spiral of increasing indebtedness has begun, the only way out for many families is a son's enlistment in the army, or the father's finding employment in India" (Hitchcock, 1966, p.18).

Jiro (1974) studied Magars of Shikha, Paktar, Kiwan and Ghar of Myagdi district and published *'The hill Magars and their neighbours'* book. He found that the occupations of the Magars are agriculture, animal husbandry, herdsman and hunting. They migrate to high altitudes for herding from lower hills (permanent residence) and vice versa according to the season. They also move their animals for herding in cultivating area in winter (vacant time of cultivation). Community plays role in management and co-ordination of herding area and herdsman, natural resources. They have indigenous knowledge and skills in ecological conservation. They cultivate millet, maize, buckwheat and mountain corns. They also kept cow and buffalo for milk, oxen for ploughing; and male buffalo, goat, sheep, chicken for meat and offering for god and goddess for health and well beings. In households, the labours' works are divided into children, youths, women, old age and males differently. In addition, they also co-ordinates with different ethnic/caste groups in the division of works, responsibilities and roles to accelerate the society. He also found that the female Magars involving in ploughing. Similarly, migrating from village to city areas, serving in the military of India and British Gurkha regiments, foreign employments were also increasing. From this migration, there was a shortage of working manpower to sustain the village ecosystem and livelihood (Jiro, 1974).

Fisher (1986) studied northern Magars of Dolpa district and their trading system, economy, society and culture from the world system/ transactional approach. Northern Magars cultivate major crops like buckwheat, buckwheat-sized grain (*Chinu rice*) a kind of millet (*Panicum millaceum*), millet, maize and potato (p.56). They also produce sheep, goats, chicken and horses. Also, they prepare wool, blanket, sweaters, mufflers and other woolen goods which are sold in Hindu areas to gain money (p.101). He has also described trades of Northern Magar as they sell the grains whatever they grow in Tibet and buy salt in Tibet. They keep some portion for household use and the remaining salt sell in the Khasan (Hindu area) in the south and get rice (pp.88-90). Due to this trade, the Magars were connected with northern Buddhist and south Hindu, and facing challenges about the cultural differences. Therefore, he further writes "As a commercial middleman, Tarangpur traders are the brokers of goods; but

as ideological hinges, they are blockers of ideas, since from each side they must hide the parts of themselves which display evidence of the others. (Fisher, 1986, p.96)

He has also illustrated declining in the trading of salt of northern Magars due to Indian salt available in the hills and mountains; "Chinese control over the Tibet in the late 1950" and tightening in the border of Nepal and China; and further declining in animal husbandry and herding due to loss of disease and bad weather (Fisher, 1986 p.96). Further, about work division to economic activities, he points out, "in contrast to the female-oriented agriculture division of labour, the world of commerce is essentially a man's world" (p.77). In such a way, changing pattern of the trade of the northern Magars, he writes as:

"In the fall, men (occasionally accompanied by their wives and sisters) cross over the passes before they are closed with snow and ice for the winter, taking with them woollen goods (scarves, blankets, sashes, sweaters), sheep goats, and sometimes horses, to sell in the middle hills. Their ultimate destination is usually Butwal in the Terai (through some go as far as India-to places such as Kanpur, Kamlimpong, and Calcutta), where they use the proceeds of their sales to buy manufactured commodities such as cigarettes, cloth, and tea, which they carry back and sell to villagers in Khasan and Bhot" (Fisher, 1986, p.77).

Bista (2004) stated, the base of the Magars' economy in all areas is largely self-sufficient agriculture. "Besides many varieties of vegetables and fruits, they grow the standard food grains: corn, millet, wheat and buckwheat in dry terraced fields surrounding the villages along the higher mountain slopes and rice in the wet fields lower down and along the river valley" (Bista, 2004, p.68). Similarly, many Magar men are skilled craftsmen in masonry, carpentry, building, stonecutting, quarrying and construction works. The Magars were also involved in animal husbandry. Likewise, "some northernmost Magars have become quite prosperous by engaging in long-range trading that takes them from the northern border to the terai, and even beyond to Darjeeling and Calcutta" (Bista, 2004, p. 68). Besides that, "most of Magar villages have a number of Gurkhas on active duty in India and Malaysia remitting regular money to their families, as well as retired soldiers drawing pensions from various military sources" (p.68). In this profession, "quite a number of Magar Gurkhas have attained the ranks commanding officers, as Colonel and Majors, in Indian and British Regiments as well as in the Royal Nepal Army and Police where they are even Generals" (Bista, 2004, p.68-70). In such a way, he describes the houses of Magars for livelihood as follows:

Their houses are built according to the style of the areas they live in, a standard which varies from one location to the next. Most traditional is the two-storey stone house with thatch or in some cases slate roofing. Many of the smaller houses in the western communities are round or oval in shape and washed with ochre or reddish mud. Magars houses in eastern hills are never round and are most often whitewashed. They have stone walls and wooden single roofs, and are two-storied with a *verandah* along the front. Some of the northernmost houses have flat roofs and consist of three storeys, the bottom one being a shelter for animals. (Bista, 2004, p.68)

Dahal (2048 BS) stated Magars were excellent qualified military in ancient and middle age of Nepalese history. In addition, Magar's occupation was quarrying in mineral ore and they could have dig-out about one-two miles distance tunnel easily in that time to extract minerals. They were also excellent peasants, agriculturists and herdsmen. The Magars brought potato from Sikkim and cultivated it in the fifth or sixth century (Dahal, 2048BS, p.191).

Shepherd (1982) found "Magar villages are often built along the crest of a ridge or else at the top of a steep outcropping. Some say that this is because the gods will not bless a person who has fields higher than his village (p.67)". He added reasons for settling in higher places as, "the village was generally built on a high spot above the land that its people cultivated. Besides, another practical and important reason in those days was that; a village thus situated was easier to defend in time of war" (Shepherd, 1982, p.67). Furthermore, ecologically he found "springtime thunder and hailstorms" (Shepherd, 1982, p.98) in the Magar settlements. He also noted that, weaving of cloth as indigenous knowledge and skills for their own use (pp.167-169). Similarly, he describes the lifestyles of Magars in economic activities as, "in old days, the big adventure of the year was the annual winter trip to the Indian border to purchase salt and other necessities. The Magars could make it through the mountains and cross the plains to the border in three days of fast walking". Also, "On the return trip, however, with many men carrying over one hundred pounds of salt, it took five days. Four or five villages would band together and depart on an auspicious day. Carrying drums with them, they would sing their way across the hot, dusty miles". In that time, "The forested plains at that time were full of wild oxen, elephants, tigers and rhinos" (Shepherd, 1982, p.27). He also described about the encounter of wild animals and stories of survival in their camping in the way. He also found engaging agriculture and animal husbandry, carpenters, handicraft, construction works and soldiers in Gurkha regiments for livelihood and economic generation. He justified socio-cultural reason in being good and brave soldiers as; "they know

how to be good followers. In their close kinship, they put a high value on obedience to the family leaders, obedience to the village decision and obedience to their gods". In the same way, "in the village, their difficult living conditions require that they work together with mutual regards for the goal chosen by their leader. In their close society, the Magars learn to bear with quirks, habits and faults of others" (Shepherd, 1982, p.104)

Gurung (1980) observed long tradition occupation of Gurkha army for India and the British. He met the Magar youngsters with *Gallawala* (recruiting agent) who were going to Gurkha recruiting depot at Gorakhpur for the Indian Gurkha regiment (GR). He further writes, "Magars from the largest group in foreign armies and it is estimated that 37,877 Magars were enlisted in the Indian army during the World War II along with 18,725 Gurungs" (Gurung 1980 pp.193-94). The main source of income of the Magars was Gurkha armies in India, the British, Singapore (Gurung, 1980, p.195). He also found that the Magars doing agriculture, animal husbandry, pottering and trading in different places for their livelihood.

Hagen (2070BS) describes the profession of Magars as being mainly military services in the British and Indian armies. Besides that, he found that the Magars were experts in mason, carpenter and infrastructure development works, and in making bridges. They were also involved in mine and extracting mineral from ore in central Nepal using indigenous technology. They also produced various bamboo baskets and utensils and sell in the market. For the Northern Magars of Tarakot of Dolpo, their economic transaction livelihood is selling salt (Hagen, 2070 BS, p.48).

Wright (2007) mentioned Magars and Gurung's traditional occupation was foreign employment from the British Gurkhas regiments because, "they are short powerful men of Mongolian cast of feature. These are the men mostly to be found in what are called the British Gurkha regiments" (Wright, 2007, p.26). Similarly, "this is the country *par excellent* of Military tribe the Magars and Gurungs, although it is also very largely inhabited by great numbers naturally of the ruling class living much the same life as a farmer and hard-working peasants, but distinct in respect of their superior position which they hold in the Hindu hierarchy" (Northey, 1998, p.9). In such a way, Hamilton (1819), Hodgson (1874), Vansittart (1906) mentioned socio-economic status of the Magars as farmers, peasants, herdsmen and focusing on excellent military tribe and bravery. In contrast, Lion Caplan (2009) argues that being an excellent military tribe is due to socio-political system adopted by rulers, decreasing the economical status of subordinate tribes of Nepal due to lack of availability of fertile land.

So they are compelled to become brave Gurkhas due to being socio-economically and politically subordinate (Caplan, 2009 p. 203).

2.2.4 Origin, Naming and Expansion of Magars

About the origin and naming of Magars; they belong to Kirat (Sharma 2067 BS p.255) and are categorized as 'Mongol-Kirānt' (Sharma, 2067BS, pp. 43-45 & 244) genealogy. He argues that Heptāl ethnic group of central Asia entered into South Asia. They followed Hinduism during the eighth century, and then became *kshetriyas* and *thakuris*. Those *Thakuris* who were unable to follow the Hindu's ritually purification in the caste system, became Magars (Sharma, 2067BS, p.243). This argument is supported by Dahal (2048) and he added Heptāls arrived here from Tibet and in long-run living; they become Magars (Dahal, 2048, p.188). Shiwakoti (2074 BS) stated Magar are *Kirānt* descendent and originated from the Patanjali country (currently Patna). The ancestor of Magars is one son *Magappā* of Kirant King of Patanjali kingdom among the ten brothers. The offspring of *Magappā* had arrived into Palpa, central part of Nepal, made a nation and expanded as Magars (Shiwakoti, 2074 BS, p.48). Similarly, Rai-Rupabung (2064 BS) argued as, in the ancient era, the Magars were '*Gandharbha*' ethnic groups which were mentioned in Hindu religious books and he clarifies Hindu religious books Gandharva were Kirats and they weren't today's *Gandharva* who play *Sarangi* (a kind of Nepali Musical instrument) and song in Nepal. Further, he validates in existing '*Gandarbha*' as a sub-clans of Magar (Rai-Rupabung, 2064 BS, p. 329).

In such a way, "the origin of *Mangar* tribe as mentioned in Kirat Chronology is a place in the north called Shin. From there, a group of people under the leadership of two leaders came to the south. The names of the leaders were *Shing Mangar* and *Chitu Mangar*" (Chemjong, 2003, p.138) and spread all over Nepal. Moreover, Sarad Chandra Das also reported about Magars kingdom in Kangpachan and Tamban valley near Kanchanjungha and after a battle with Tibetans they came into Nepal (Vansittart, 1906, pp. 84-86). "Magars built Jong (forts or Castles), wherever they settled and called them Mangar Jong" (Chemjong 2003, p. 139). Besides that, in Limbuwan Sikkim, when Phunchho Namgyal (1641-1670) became King, the chieftains of Magars and Limubs opposed him and did struggle. But, the king dominated them with the help of the Tibetan Army (Shiwakoti, 2074 BS, p.79). It shows the Magar's existence in eastern Nepal and Sikkim was from the ancient era. In addition that Francis Toker (1957) claimed that some group of Magars came from Chitaur. In Chataur Rishi Raj Rana was the Chief and after him, his 13 descendants ruled the Chitaur (Toker, 1957, p.21). Subedi (2063 BS) argues that the Magars are descendent of Lichhabi; the proof is a stone

statue erected by Mandev (a Lichhabi king) in *Changunarayan* which matches with the Magar's face and it can give a full proof of descent of *Lichhabi* (Subedi, 2063 BS, p.5).

Similarly, Gurung (2067BS) argues that *Nagraja, Nag Magar Raja* written in Buddhist literature was Magars; so, they are those historical ethnic groups (Gurung, 2067 BS, p.23). Pokharel (2055 BS) argues that the etymological meaning of 'Magadh' is Magar and it was the land of Magars (p.104). They were scattered all over the Makwan (Makwanpur) to Mahakali River and those were respected as Mundi (Mundri) (p.495) and Lakhmandal was an ancient Magar nation situated on the bank of Jamuna River (Pokharel, 2055 BS, p.496). Furthermore, Michel Witzel (1991) "Magars were apparently known already to Mahabharata as Maga = Mang (Bombay), to Purans under the Name Mangar and in Nepalese Copper Plate inscription of 1100/1 AD as Mangvara" (p.19). Further he argued, "Aramu-di (or Aramo-di might preset a Magar name for the area this 'King of Nepal' had under his reign. If this indeed was the case, a Magar word probably names of the river and a region, would be arrested already in the 8th century A.D" (p.20) in "battle between the Kasmiri King (Jayapida) and 'Nepalese King' Arumu-di took place on the *Kala Gandika* the modern Kali Gandaki" (Witzel, 1991, p.19). Similarly, Sylvain Levi stated, Magars as aborigines of here and the king of Gorkha were from the same ethnic group, however, their blood was mixed with Hindus (p.161). Besides, the Magars and khas had an old relationship from the fourteenth century. The Magars changed their ethnicity into a caste system when Brahman became in power. Those Magars who did not went into Khas, couldn't get sacred thread (Janai) and were divided into two groups. He also noticed that Magars' language was going to disappear due to mixing with Khas language (Levi, 2005, p.174).

Hitchcock (1966) argued "Magar origins are lost in obscurity. The tribe seems to have been part of a very ancient reflux of Mongloid, Tibeto-Burman speaking peoples into Nepal, probably from the north and east". However, when he asked with Magar of Banyan hill of his study area about the questions, 'where they came from?'; 'When came here?' But the local Magars answered "we have lived here always". So they were living there from immemorial time (Hitchcock, 1966 p.4). About the origin of Kaike Magars, Fisher (1986) described mythical tales told and retold by local people. According to the story; Dolpo Kaike Magars were the son of a pregnant woman who had fled from an unspecified village of Kalyal Kingdom. She ran away from the bank of Bheri River to the north and reached Tarakot (actually Tichurong) and gave birth to a boy. That boy grew up and he captured an angel who was bathing with her friend in milk's lake. He married her and reproduced three sons; they

were the ancestor of Budha, Rokaya and Gharti Clan. Shepherding by these three sons; a female goat was always hiding in a grazing area and found away. One day, they found that she was nourishing milk a child. They brought the child home and he was the ancestor of Jhankri clan of Magars (Fisher 1986, p. 35-38). Similarly, Opptiz (1983) describes the three variant tales of Magar origin in the Northern Magars of Rukum of central Nepal; especially, from Hukam, Maikot and taka villages. He examined those three origin stories and concluded that "the Magars of the North, or at least the local branches of Taka, Bacchi, Hukam, belonging to the Deopahari- Gharti-pun and Budha, do not trace their origin to an alien and faraway land" (p.199). The three stories collected from the Northern Magars were "stating in unison a local origin of their first ancestor" (Opptiz, 1983, p. 200).

In the similar way, Whelpton (2007) kept different argument as "multiple origins is even more obvious for the Magars as a whole" (p.14). The "term 'Magar' was perhaps once simply a prestigious title that was adopted by the numerous otherwise concentrate groups and became Magars (Whelpton, 2007, p.14). "The aboriginal stock of Nepal is most undoubtedly Mongolian. This fact is inscribed in very plain characters, in their faces, forms, and languages. Among the aborigines of Nepal must be counted the Magars, Gurungs, Newars, Sunwars, Khambus, Yakhas, Yakthumbas, Limbus, Murmis, and Lepchas" (Vansittart, 1906, p.7). Similarly, "Magars were Mongolian people who had migrated into Nepal in the predawn of history. Many ethnic groups had legends that told how they had come to Nepal from Tibet or some other country, but not the Magars. For them at least, history simply began and ended in Nepal" (Shepherd, 1982, p.11).

Chemjong (2004) argued "the Chinese and Burmese peoples call Mang or Mong form Mongolians; and ar or arui means children. So Mangar means children of Mangols" (Chemjong, 2004 p.141). Jiro Kawakita (1974) found a story as four brothers (senior elder Brahman, second elder Thakuri, younger Kāmi and youngest Magar) went to do worship Chandi goddess and there was needed to sacrifice a pig. The youngest brother said 'I will do' in Nepali language, so, he became Magar. The Magars do all works as a name (Kawakita 1974, p.166; Baralmagar, 2050 BS, p.23). According to Dharanidhar Dahal, Magarat word is corrupted from the word 'Makarrāt' and the habitants of Magarat are Magars. They were the descendants of '*Gandharbha*' described in Hindu Sanskrit literature. Furthermore, according to Naradmuni Thulung Magar word is corrupted from the 'Magadh'. Magadh was an ancient country of south Asia (Rai-rupabung, 2064 p.326). Similarly, according to Dharma Prasad Shris, in between Mahakali River and Chandrabhangga River, there was 'Mahar valley'.

When a group of people came from the Mediterranean Sea to the southeast area at Mahar Malley and the valley of the habitants was called 'Mahar'. Later, the word 'Mahar' got corrupted and became 'Magar' (Shris 2038, Cited by Baralmagar 2050 BS p.2). In Magar language; '*māhāre*' means shepherd or herdsman, and *Māhārā Nungke (ānke)* means to 'go to herding cattle'. Ancient Magars were herdsman, so this word is corrupted in a long time run and became 'Magar' (Thapamagar, 2071BS, p. 14; Sinjali, 2071BS, p. 5).

Furthermore, Kirkpatrick (1811) wrote, "Muggur tribes" (Kirkpatrick 1811, p.123) for Magars and in Sikkim Magars are called as 'Chwang' (Jorge L Harris and others 1973, Cited by Baralmagar, 2050 BS p.21). In addition to that, the Magars are called 'parai' or *pārkotyā* because they were the habitants of Sapta-Gandaki region and the Trisuli, Budhi, Dharmawati, Champawati, Matsyandi, Sukala and Krishna of seven Gandak also called Parkot in ancient time (Baralmagar 2050 BS, p. 22). Similarly, the Magar word is derived from the 'Mang' which means beard and moustache and *Māle* means not having. Physically, the Magars have few hairs in their face and body; so *Mangar* name was derived (Ghartimagar 2053 BS, p.22) accordingly.

Vansittart (1906) mentioned about Karnataki Malla dynasty; "the sixth or last king of the dynasty, by name Hari Deva, had at this time (about 1100A.D.) a Magar in his service, who through the machinations of the ministers, was dismissed" (p.16). This man returned home and praised Nepal as having houses with golden roofs and golden *pranālis* (or *dhārās*) to king Mukunda Sen. Hearing this, brave and powerful monarch invade Nepal (Vansittart, 1906 p. 17). With this *Rājā* the Khas and Magar Castes came to Nepal (Wright, 2007, p.171). Furthermore, Kirkpatrick (1811), Hamilton (1819), Hodgson (1874), Wright (1877), Vansittart (1906), Landon (1928), Northey (1937, p.7) were stated massive spread out of Magars in Nepal's territory from central Nepal with unification process of King Prithwi Narayan Shah.

Also, Bista (2004) gave the reason for the spread out of the Magars as:

"There are several reasons for this kind of distribution. First, there is the general trend of eastward migration due to the limitation, low rainfall places on the expansion of arable land in the west. Second, there were land grants made to Magar soldiers I Compensation for their service. Third, since many Magar men are skilled craftsmen in masonry, carpentry, building, stonecutting, quarrying, etc., they have tended to migrate in search of employment in these skills. As evidence of this, there are several sizeable Magar villages in the eastern hill areas near mines and slate quarries" (Bista, 2004, pp.67-68).

Moreover, Thapamagar (2071) stated expansion of Gorkha Kingdom, to extract minerals from the mine ore, excellent in mason and carpenter for building, bridging, warfare, agriculture and animal husbandry; and Gurkha army for East India Company of the British empire were reasons of Magar spread out (Thapamagar, 2071 BS, pp. 22-26).

2.2.5 Overview on Political Aspects of Magars

Politics is power and social status; and opportunity of development of the nation. Health care and services are governed by politics. Therefore, Light and Schuller (1986:9) explains, "Medical care and health services are the acts of the political philosophy" (cited by Cockerham 2012, p.2). If an ethnic group has political access or power, then politics helps to develop indigenous knowledge, ethno-medicine and indigenous medical practices. Otherwise, it destructs their indigenous knowledge. The political aspect of the Magars is unclear and lacks well-documentation. Here, political access and political aspects of the Magars are trying to dissect into available literature.

Vansittart (1906) described, "of very ancient Magar history we know nothing, and the first time that they came into prominence as a great power is about A.D. 1100, when we hear that Mukunda Sena, the Magar King of Palpa and Botwal, invaded and conquered the Nepal Valley" (Vansittart, 1991, p.83). Similarly, "The chief of Rising, Ghiring, and Gajarkot were related to Palpa Family, ...Chaubisia Chiefs were really Magars" (Vansittart 1991, p.84). Furthermore, "When the colony from Chitor first took possession of Palpa it belongs to a Magar Chief, and people were same tribe" (Vansittart, 1991, p.84). Most of the Magar chiefs disguised their title into Rajputs due to the influence of India and Hinduism (Vansittart, 1991).

Hamilton (1819) stated, "before the arrival of the Rajuts, it is said, that this nation consisted of twelve Thums, or clans, the whole members of each being supposed to have a common extraction in make line; and a man and woman of the same blood could not intermarry" (p.25). He further writes, "Each *Thum* was governed by a chief, considered as the head of a common family" (Hamilton, 2007, p. 25). The "Gandharba Sen of Palpa and Binayakpur made a considerable addition to his dominions, having, with the assistance of his allies, the Rajas of Gulmi and Khanchi, seized on the territories of an impure Magar chief who resided at Balihang" (p.160). Further, "this chief, of whose family there are no remains, had large possessions, both on the hills and plains, especially on the latter. These were divided among the three allies, Palpa taking the best share," (Hamilton, 2007, p.161). Further, he writes, "The allied chief of Palpa, Gulmi, Khanchi and Argha, as I have mentioned, about the

beginning of the eighteen century, destroyed the Magar Chief of Balihang and divided among themselves his dominations, both on the hills and plains (Hamilton, 1819, reprint 2007 p. 247). Similarly, "when the colony from Chitaur first took possession of Palpa, it belongs to a Magar Chief, and the people were of the same tribe" (Hamilton, 2007, p.167). Similarly, Lecomete-Tilouine (2000) described the continuation of cultural symbolic system in Musikot about the ancient King's representation in Dashain festival. The offspring of Thakuri Kings sacrifice the Male-buffalo in Nawami and the offspring of Saru Magar King gave Tika at Dashami in Dashain. She has also explained this ritual Magars King's agent and tutelary divinity for Saru Magar who gives *Tika* for Thakuri. The sacrificing male Buffalo by Thakuri is political power. Here, she collected tales of two kings and ritual of the festival gives a clue of Magar Kings was substituted by the Thakuri King which was brought by the Magar King's brother, so, political acceptance and co-existing seen in ritual (Locmete-Tilouine, 2000, pp 143-167). Besides; "the Magar Kingdom of Palpa, which did not submit to the Gurkha Raja until 1800" (Northey, 1998, p.8).

Sarad Chandra Das (1881) travelled from Darjeeling to Sikkim to Tibet. He found Kangpachan and Tamor valley there was Magar chief of the nation in history. Tibetan peoples of Kangpachan felt oppression by the chieftain, so they killed him. Later on, the chieftain's widow got information about Tibetan's conspiracy of killing. She took revenge inviting them to a funeral feast serving poisoned food and killed thousand in numbers for guilty of the crime. Then Tibet sent the army to avenge the chieftain widow and invaded several forts. She fought with bravery for three months. Lastly, the Tibetan army cut-off the water source of the fort. She opened the reservoir of water towards Tibetan troops to show that there was plenty of water and difficult to win. Tibetan troops raised the siege and went to few distances back to see the Magars movements. Then she collected her peoples and left the fort (Vansittart, 1906 pp.84-85; Landon, 1928, vol II, pp. 44-45). Hamilton (1819) found information of impure Magar Chief in *Kumau* west of Kali (Mahakali) river around 1450/53 AD. The Hindu pure chief (Raja) from the Jhansi killed him (Hamilton, 2007, pp. 272-73).

"In 1703, an agreement between Patan and Bhaktapur provided that if either party broke its terms they might be plundered with impunity by the 'Khas and Magar Omraos' (chief, headman)" (Regmi 1966, pp.162-3; Whelpton, 2007, p. 32). It shows "Magars and Khas were becoming an important factor of the court politics of the three kingdoms" (Whelpton 2007, p.32). Similarly, "Magars and Gurungs had long been part of the military forces of Gorkha as of the Chaubisi states; Magars, in particular, could until the eighteen century be 'promoted' to

Chhetri status" (Whelpton, 2007, p.59). Further, he describes, "There were still some important Magar Bhardars including Abhiman Singh Rana, one of the victims at the Kot but these seemed to be regarded as 'honorary parbatiyas', and 'Magar and 'Chhetri were normally exclusive categories. Nevertheless, many Magars could still regard themselves as Gorkhali" (Whelpton 2007, p.59). Later on, during the Panchayat regime, the solidarity of Magars has decreased and further he wrote that, "the role of this local elite was probably greatest where there were no strong regional or ethnic ties providing a sense of identity between the national and family level. In Arghakhanchi, for example, a hill district south-west of Pokhara, Magar solidarity was relatively weak" (Whelpton, 2007, p. 177).

Northey (1937) explained, "regiments of this description are Kali Bahadur, composed solely of men of the Gurungs, and the Purano Gorakha, of men of the Magar tribe" (Northey, 1937/ reprint 1998, p.144). Similarly, "the Palpa Battalions are recruited very largely from the Magar tribe, as the Magars predominate in this part of Nepal, and two of them the Sabuj and Bhawanidal regiments, formed part of the second contingent which served in India during the Great War, those two battalions being stationed at Dehradun" (Northey, 1998, p.185). It shows the Magars involvement in the unification of Nepal and defence forces.

Hitchcock (1966) found that the headman has the role to liaise villagers and Nepal Government in Banyan Hill. The disputes of villagers were settled down in presence of the headman because of his role as an arbitrator and maintained solidarity of society. "The Kot is a symbol of the political and religious unity of the Thum and the interpenetration these two spheres" (p.101). From the Banyan Hill, Magar was elected in parliament from Nepali Congress, but parliament was dissolved due to political changes. He found a representation of Magars in National Politics and bureaucracy at lower levels (Hitchcock, 1966). Similarly, Fisher (1986) illustrated headman (Mukhiya) and his role, selection process and arbitration, liaison between government and villagers in local politics. He also described frequently governmental official visits to check trades and taxation purposes, and official exploitations even beating locals. He also found political situation of Nepal and election became expensive practice who won the election at the parliament level was benefited than the traders. The elected persons at the village level or national level can earn from deer hunting and musk trading (Fisher, 1986). Similarly, Magar (2063 BS) examined the cause and impact of conflict among the Magars and she has described how the origin of Maoism became strong and sprung in the Magar territory. Further, she illustrated socio-economic, geographic, ethnic, lingual, religious and cultural discriminations compelled Magars fight against contemporary rulers. In the war, the majority of deaths and

casualties were from the Magars. However, some Magars were able to grab politically higher posts due to their involvement in the war. In general, the impact was migration, stress due to death and casualty, fear from both the government and the Maoists. She further claims that Maoism became strong due to the Magars (Magar, 2063 BS).

2.2.6 Overview on Socio-cultural Aspects of Magars

Hitchcock (1966) described family, relationship, kinship, social structures, life cycle rituals, god and goddess, feast and festivals, work and livelihood, dance and songs, woman's status of Banyan Hill. He has described that the Magars had a joint family but a tendency to a nuclear family is rising. Marriages are done in a family arrangement; somewhere boy and girl love each-other and elope for marriage. Sometimes, they marry by abduction. Widow marriage is in practice. There was a culture of remarriages as *Jari* marriage, *Sari* Marriage and *Fundi* marriages too. The Magars can re-marriages easily. To validate the marriage, the girl's parents and relatives should give *Tika* (Yoghurt and Rice). Females get a gift (*Pewa*) as their property from their parents or brothers (*Maiti*). If any woman falls in hardship or gets trouble after marriage, their brothers give her a piece of land as a source of income for her livelihood. They are allowed to marriage maternal uncle's (*Mama*)'s daughter (*Sāli*) but restricted with sister's daughter (*Bhānji*) (pp.35-47). About the kinship, the Magars have a lineage of their sub-clans such as Sinjali, Pulami, Lungeli, Hiski from the Thapa and Rana clan. In patriarchal property, the males become '*hakdar*' but unmarried daughters also get shares. The daughter and sisters called 'Chelibeti'. In-laws kinship from the side of daughter and sisters are called '*Kutumba*' to the brothers, and *Kutumba* has a great role in life cycle ceremonies, worship and religious rituals. The married male says as *Mawali* for his wife's parents and brothers. There is a practice of ritual friendship ('Mit' or 'Mitini') in Banyan Hill to develop new kinships. Further, he found the *Dashain* festival was for the renewal of Kinship and tie-up them. In this festival, all people get gathered in the eldest member's home of the clan and celebrate festivals (pp.59-72). There is also a culture of group working pattern in the village; *Porima* or *Orima*, *Madat*, *Saghau* and *nimeki* systems. He also noted song and dances as *Rodi*, *Kahaura*, *Jhabre*, *Nachari*, *Ghanto* and existence of *Rodi* houses in Village (pp. 85-94). He found that the Magars have simple philosophy (Hitchcock, 1966).

Fisher (1986) studied Northern Magars of the Dolpa from world system/transaction approach. He found Magar culture being affected by Tibetan Buddhist culture and south Hindu culture. Further, he wrote:

"As a commercial middleman, Tarangpur traders are brokers of goods; but as ideological hinges, they are blockers of ideas, since from each side they must hide the parts of themselves which display evidence of the others. Instead of being cultural brokers between two alien groups, the men are effect cultural brokers (or idea of men) for their women. This blockage of ideas between the two contrasting ecological and ideological zones to the north and south results in a kind of integration between the three symbiotic regions that is distinctively economic" (Fisher, 1986, p.96)

He also illustrated the role of males and females in the family, agricultural work, exchange of labour, trade and society, co-operative systems in Magar culture. Generally, the males are involved in trade and the females in agriculture and weaving works. The Magars do marriage within their ethnicity, however, there is intermarriage with Thakuris and said as 'Thakulla' for Thakuri due to intermarriage with Magars whereas the Magars do not prefer marriage with Bhotias (Fisher, 1986).

Shepherd (1982), found songs and dances as *Ghantu, Oholi, Jhora, Nachang (Marunni), Jhabrya, Phaguwi, Karhuwa, Juwar Geske* and *Rateuli*; and further, he has described the performing seasons and ways in socio-culture settings (pp.258-262). He observed that "usually married in their teenage years" (p.68) and the custom of "marry the widow to her husband's younger brother" (p.72). In death ceremony, he noticed that "no meat and salt in it the thirteen days of mourning for the wife; this assists the departed in reaching heaven more quickly, for the eldest son, however, the mourning period was five days and for the other children only there"(p.108). Moreover, he has described, "At the end of the mourning period, a death feast is required. The family is obligated to butcher a pig and feed the pallbearers and all the clan relatives who have abstained from salt and meat". So, mourning ceremony became "expensive affairs for a family" (p.108). The reason for doing mourning ceremony was "One gets the feeling that the larger the feast, the more pleased the departed spirit. This has a practical side, for if the deceased is happy, his spirit is not so likely to cause sickness to his family at a later date"(p.108). He found, "there are numerous festivals days, death ceremonies, marriage ceremonies and other holidays which are celebrated as well. Thus, there is a minimum of nine to ten holidays per month and usually quite a few more" (p.93) for celebrating ceremonies in Magar socio-culture (Shepherd, 1982).

Baralmagar (2050 BS) studied the Magar culture of the Palpa, Tanahun and Syangja districts on 2038 BS, submitted on 2039BS. He mentioned Magar's clans and sub-clans, more than thousand sub-clans in *Ale, Gharti, Thapa, Pun, Bura (& Budhthoki)*, and *Rana* clans (pp.

155-169), *Roka*, *Jhankri*, *Chhantyal* clan and sub-clan of Magars (pp.28-37) in socio-cultural setting. He has found that most of the Magar families were joint family and leading by old adults or seniors in kinship. The Magar brothers greet touching feet of their elder brother's wife (*Bhajyu*) which is different than local Brahman and Chhetris. In family work division is not clear however, family head leads work division as per necessity. In general, outside works are done by males and internal works of household by females. Most of worship and sacrifice for propitiating of gods and goddess, Ghantu worship are for health and well-beings. Most of the brothers after marriage live together for a long time and can be separated doing ritual 'Mana Bhakke' where one *mana* rice per family cooked and eaten together and get separated. The gathered respected persons of the village divide the properties of the family and the shares are accepted by brothers. He also illustrated the kinship among the Magars and their family relationship and economic system like 'Horatya' system making groups of 10-15 households do agricultural works (pp. 41-57).

He found the pregnant woman and her husband considered as impure to worship as well as for hunting. After giving birth, the family and male lineage are considered as impure for 10 days or until the naming ceremony is over. They conduct a naming ceremony on the 11th day, but it can be shortened on the 3rd, 5th, 7th, 9th day according to the situation of the family and clan. *Kutumba* goes to a priest and takes the child's name. The enchanted cow's urine, he sprinkles it into household and fields; and gives name to the child. Similarly, the Hindu influenced Magar do *Chhaiti* ceremony on the sixth day of birth. In the sixth month for son and fifth month for daughter, weaning (*Bhātkhuwāi*) ceremony is held. Generally, the Magars have hair cutting ceremony (*chhewar*) for males and giving *Ghānghar* (*Gunyu choli*) ceremony for girls in or after the 5th years' in an odd year. Maternal uncle (*Māmā/Kubā*) has a great role in *Chhewar*. Parents carry out *Gunyu Choli* ceremony. He also found arrange marriage (*Lagnyā*), love and elopement, marriage by pulling, *Jari* and widow marriages. The divorce culture is '*Sinka Suta Bharake*' or '*Sinkipar*' in presence of villagers. In this process of '*topi bharaune*' charge if a female wants to divorce and '*Phāndo Bharaune*' charge to the male which is decided in villager's gathering. Similarly, in death rituals, most of the Magars burn the deceased, but in the past, there was a custom of burying custom. The corpse body of *Lāmā* (shaman) is buried (high hill area is preferable). He also illustrated *lām hwāske*, *misiwat lohoke*, *myārmhā/mirmhyā donch* in corpse burning or burying custom. On the 3rd day, they sacrifice chicken and worship. On the 10th day, male lineage gathers for *di dāke* (dasgatra). On *Ghot* day, they sacrifice chicken and worship and do *chhā-sidi chhuke* and *Ungyā Bhākke* customs (pp.59-85). He has

described folk songs and dances, feast and festivals and worship and offering so many Godlings and natures for health and well beings (BaralMagar, 2050, pp.85-129).

Oppitz (1983) analysed three tales of Magar's of Magar-Kham speaking northern area. He also analysed wife-givers (*maiti*), wife-receivers (*Bhanja*) and their relationship, marriage chain in between three clans of Magars and restriction of marriage within clan. He also explained the custom of "when a woman is pregnant, her husband is barred from hunting" (p.222) and he illustrated "the Magars, retaining their own identity intra-tribal marriage permission and externally playing "clan" exchanging women" (Oppitz, 1983, p.226).

Ghartimagar (2071 BS) mentioned Magar rituals, worshipping, god and goddess of Rolpa districts. He also described *Pitrapuja*, *Chulha puja*, *Gorpuja*, *Bhumya puja*, *Barāhā puja*, *Nauladevi puja*, *Gaipuja*, *Bhaisi puja*, *Diwali puja*, *Udheli-Ubheli puja*. Similarly, he has stated about traditional Magar custom and kinships (Ghartimagar 2071 BS)

Dhakal (1996) has illustrated the 'Bheja' tradition of Magar society. According to him, Bheja is a traditional social system that serves an integrative role in Magar society by fostering community solidarity and social consensus. It gives the feeling of a single extended family in the community (p.46). The functions of the Bheja are religious function, agricultural function, economic significance, resource management, nutrition, dispute mediation, community solidarity and entertainment; so, "all social functions are generally determined and monitored by the *Bheja* (p.47). Bheja selects the village chief (Mukhiya) and *Pujaris* in a gathering of villagers, hence "*Bheja* fulfills the community need" (p.48). Furthermore, "*Bheja* also fixes the labour wage, arrange common management (e.g. forest resource management), and mechanism for mediating community dispute" (p.48). Certain Magar Bheja "may allow even the non-Magars to become members, including the untouchable households of the same and a neighbouring cluster" (p.41). Although Bheja is a traditional organization of Magar society, it is degrading due to multiparty system, politicization, governmental institution, police, court, administrative office and re-structure of government in village level and government having no priority. Degradation of Bheja in Magar society, there is "an increase in social strife and community disintegration" (p. 47). In addition, he pointed out there is a necessity to preserve this social institution for sustainable development (Dhakal, 1996).

In such a way, Gurung (1980), has described the Nepalese dress and fashion in the occasion of Devghat Maghe Sakranti festivals, in his words:

"The people gathered at devghat were of immense variety and diverse tribes and castes. There were Majhis and Kumals in loin-cloth, Tharus and Darais in simple

cotton, Chepang, Tamang, Gurungs, Magars, Newars Chhetris and Brahmins in their hill dress. The women were more colourful ranging from a blue dress of the Tamangs and Newars, a dark maroon shade of Magars and Gurungs and scarlet red of Hindu Brahmins and Chhetries. The native Tharu and Majhi women in pony-tails wore strings of cowrie shells and colourful beads and their hand and feet were elaborately tattooed" (Gurung, 1980, p.251)

Hamilton (1819) stated food custom of Magars as; "they eat copiously the flesh of hogs, goats, sheep, ducks, and fowls, but now abstain from beef. They are addicted to intoxication, and are excessively cruel and treacherous but they are men of great bodily vigour and mental activity" (P 24). He noted that, "they have only one wife" (Hamilton, 2007, p.24). However, later on Hitchcock (1966), Fisher (1986), Baralmagar (2050BS), Shepherd (1982) found cases of polygamy were rare. Similarly, he observed, "Magars men dressed as coarse cotton cloth *Khadi* and *Changa*" (Hamilton, 2007, p.217) in Magar society. In such a way, Major, W. Brook Northey (1937) reported Magar dress as Gunyu, Pharia, Choli, Matha (Patuka), Ghalek, Luhup (Majetro) by females and ornaments Shirphul, Shirbindu, Chandrama Kanta, etc on the head, Madhairi; Chepte ring in the ear; Pote (kanchi), Kantha, Jantar in the neck; Phuli, Bulanki in the nose; Raiyān bangle in hand; Kalli in foot and males dress were Gaado, Bhoto, Kachhad, Nepali Cap. In addition to that, he found, "the houses, with thatched roofs and walls coloured with red clay and surrounded by patches cultivation have a comfortable and cheerful appearance" (p. 189) and "majority of the Magars in Palpa speaks their own dialects, known as Magarkura" (Northey, 1990, p.190).

Vansittart, (1906) explained Magars' marriage as "if a boy, without being engaged to her, meet a girl, falls in love, run away and marries her, he and his bride cannot approach the girl's father untill called by him"(reprint 199,1 p.50). Further, "when the father-in-law relents, he will send word telling the boy that he may present himself with his wife at his home on a certain hour of a day". He added, "on their arrival, the father-in-law will paint a spot on their forehead with a mixture of rice and dahi (Tika), then the boy and girl will have to make submission by bending down and saluting him. This is called *Dhok Dinnu*" (p.51). In such a way, he further writes:

"Amongst the Magars, it is customary for marriage to be performed by Brahman, and the ceremony is conducted in much the same way as the ordinary Hindu marriage. There is the marriage ceremony 'Janti' which is so timed that the party reaches the bride's house after midday, where it is first greeted with a shower of rice-balls, and

then feasted by the parents of the bride. The actual marriage takes place at night when the ceremony of 'Phera' (Circumambulating the sacred fire) is performed and afterward the 'Anchal Ghanta' (knotting a cloth which is stretched from the bridegroom's waist over the bride's shoulder). The latter ceremony is said to constitute the essential marriage tie" (Vansittart, 1991, p.51)

Vansittart (1906) wrote inter-caste marriage as; "In case of Brahman with Khas, or Khas with lower grades, there can be no marriage. Neither can a Magar marry a Gurung of vice versa nor can a Solahjat Gurung marry into the Charjat of Vice versa" (p.49). About caste hierarchy, he describes as, "But, Magar women could have intercourse with Brahman and Rajputs or Kshetris and their progeny is lower than father's caste" (p 83). Besides that, he has claimed, "the Magar women have consequently intercourse with the Brahman and Rajputs and probable the greater proportion of the original Khas, were the progeny of Brahman and Rajputs of India with Magar women" (Vansittart, 1991, p.83). In this matter, Bista (2004) stated, "A few Magar women do marry outside of the group, but the men –unlike Chhetri or Brahman men –almost always marry within the groups" (p.70). Further, he argues, "Magars as an ethnic group are endogamous" (Bista, 2004, p.70). Similarly, Historian Baburam Acharya included Magars in Kirant (p.13) which word 'Kirat' is famous in Sanskrit literature. Moreover, he described, "Nepali society is constructed due to union between Aryan and Kirant citizens" (p. 83). He further writes, "There were two types of culture and civilizations Khas and various ethnic groups of Kirant who were developing their own culture and civilization. It is better to say, Nepali culture and civilization is a union of two culture and civilizations with Aryan civilization and culture" (Archarya, 2068 BS, p.83)

2.2.7 Religion, God, Goddess and Godlings of Magars

Wright (1877) stated, "the Gurkhas, Magars, and Gurungs, are Hindus. Their religion and custom are very much the same as those of the inhabitants of Hindustan, and they are divided into the same castes, and observe the same rules as regards food and water" (p. 31) but low caste (p.30). The Magars eat pork but not buffaloes' flesh; while Gurungs eat buffalo but not pig (Wright, 2007, p.30). Similarly, Landon (1928) reported as, "Brahmin and Rajput were given a higher social standing than the Magars and Gurungs" (Landon, 1928/reprint 2007, vol. II, p.241). However, Kirkpatrick (1811) observed as "Khas and Magar tribes are kept into the Chhetri class" (p.123) when he visited Nepal (in 1793AD). Besides that, "Magars, in particular, could until the eighteen century be 'promoted' to Chhetri status (Whelpton 2007, P. 59). But, in *Muluki Ain* 1854 (1910 BS), Magars kept in *Non-enslavable Alcohol Drinker*

class; and only water was accepted by the Brahman (Hofer, 2004, p. 22). Further, he clarified Magar's position in Muluki Ain as "the Magars also wanted to consider themselves Vaisya, but Brahman categorized them in the ranks of the *Sudra*" (Hofer, 2004, p. 91).

Furthermore, Hodgson (1874) described as "The Gurungs and Magars are, in the main, Hindus, only because it is fashion; and Hinduism of the Khas, in all practical and soldierly respect, is free of disqualifying punctilios" (Hodgson, 1874, Part II p.40). In such a way, Vansittart (1906) also explained as "The Magars and Gurungs are so also nominally, but their Hinduism is not very strict". (p. 49). "Among the minor Hindu deities, Diorali, Chandi, and Devi are those specially worshiped" (p.54). He also described the caste system as, "Caste rules with regards to food only apply to one description, viz 'dal and rice'. Should a Brahman of the Opadiah class prepare 'dal and rice' all caste can eat of it. Magars and Gurungs will not eat the above if prepared by a Jaisi Brahman" (p.56) Furthermore, "Whilst bachelors Magars, Gurung, Limbus, Rais and Sunwars will eat every kind of food in common, and after marriage even, the only thing they draw the line at, is dal and rice" (Vansittart, 1991, p.57). In addition to that, Vansittart (1906) described Hinduization process as, "the mountaineer princes were persuaded to follow the doctrines of the Brahmans, and many of the subjects and clans of these princes were induced to follow the example set them, but a large number refused to be converted". Further he wrote, "Brahmans granted the sacred thread, whilst they denied it to the latter, and hence have sprung up tribes called Thapas, Ghartis, Ranas etc., some of whom wear the thread and are called Khas, whilst the other do not wear the thread and remain merely Magars" (Vansittart, 1991, p.69). About the Hinduism and Magar's rituals Northey (1937) observed that, "One of the largest of the Mongolian military tribes, the Magars have adopted this (Hindu) form of ritual in its entirety for all their ceremonies, and the remaining tribes practice it to a large extent" (p.109). Further he writes "the usual dish for all big ceremonial occasions is buffalo and this last all Gurkhas, except Brahman, Thakurs, Chhetris and Magars, will eat without any hesitation in their homes"(Northey, 1998, p.109).

Bista (2004) describes religion, as "Majority of Magars are Hindu and as such they have Brahman priests who lead them in the same pattern of religious customs practiced by the Brahman-Chhetries" (p.72). He added, "Most Magars Worship Vishnu, Mahadev, Ramachandra, Krishna, Ganesh Lakshmi, Saraswati, Bhagawati etc" (p.72). But Northern Magars follows Buddhism and he stated, "Buddist Magars employ lamas to perform life-cycle rituals instead of Brahman" (Bista, 2004, p.74). Despite that, he pointed out indigenous ways as "Those Magars who do not employ a Brahman priest follow slightly different rules. In the

place of the Brahman, one may employ one's sister's son or a daughter husband to preside over the various religious ceremonies" (p.72). Further he has explained, "the practice employing the sister's son or daughter's husband as a priest is not entirely peculiar to Magars" (Bista, 2004, p.72). But, Chemjong (2004), argued "Dhami was their religious priest" (Chemjong, 2004 p.143) of Magars. In addition, Watters (1975) has explained shamanism tradition among the Magars which is near 'Siberian Shamanistic Traditions. In Magars, it is said "Ramā" in Northern Magars and rest of the places said Lāmā (Watters, 1975, pp. 123-168). Thapa (2063 BS) also found the Magars of Dolpa follow Buddhism and in Rolpa and Rukum districts majority of the Magars follow Hinduism. However, worshiping god and goddess practices of the study area was different than Indian Hindu culture (Thapa, 2063 BS).

Fisher (1986) examined northern Magars who are influenced by Buddhism and Hinduism both. In following Hinduism rituals "local deities are also worshiped in many rituals. The most notable being a nearly month-long religious festival in the winter with daily dancing – part of the cult of mountain gods –which is neither Hindu nor Buddhist but entirely Indigenous" (p.23). Furthermore, "Tarangpurians worship their gods as shrines and natural objects, such trees, as well as at Buddhist and Hindu shrines and objects wherever they can find them" (p.24). Beside that, "they acknowledge different god as having different powers in a different location; hence god are not in competition with each other" (Fisher, 1986, p.24).

Hitchcock (1966) has described that flow strictly Hindu worship rule as done by Brahman priest from headman (elite class) of Banyan hill, but the majority were not doing so. He found, peculiar worship practice as, "worships of Lakshmi, the consort of Vishnu by sacrificing hen" (p.26). Similarly, he stated, Hunter Godling, Sansari Mai, Bayu, Mari, Grandfather and Grandmother, Mandali, and household Godlings (pp.25-34) found locally which are connected with health and well beings. Similarly, Gary Shepherd (1982) studied Magars of Tanahun and Arkhala Nawalparasi and he has listed 58 local deities as; *Tin kannya Mayu, Siddha, Baday Chuli Mayu, Sunay Jhankari, Dhokya Budha, Palu Budha, Maharaja, Lakdha Budha, Lata Jhankari, Namurung Budha, Gasai Budha, Bhuyar, Jhakari, Arma, Aytesing Lama, Deota Budha, Bhaguwan Barajyu, Jala Bhuyar, Bijay Budha, Jabar Bhuyar, Somay Siddha Jhankri, Lachiman Deota, Pacha bhaya Jhankari, Bala Siddha Jhakari, Jala Siddha, Dudhe Jhakari, Dhadako Siddha, Tolandi Devi, Mandali Barajyu, Man Singh Barajyu, Disaykoti Barajyu, Mandali Buje, Budha Barajyu, Pureni Buje, Bankata Bajyu, Chepi Budhiya, Bhariya, Susuling Budha, Godami Budha, Jaisi Budha, Bolha Budha, Lama Budha, Chandi, Deorali Mata, Dahar Gaidu, Chyu, Dhadako Sddha, Ranani Budhiya, Phoder, Mani Ram, Phal Budha, Dhole*

Budha, Wantaki Lama, Kala Bhairum, Chature Saru, Ayari Budha (Shepherd, 1982, pp.52-24) were the local deities worshiped by the Magars for health and well beings. He also noticed that "the priest, an unmarried Magar boy, goes and prepares an altar for the sacrifice" (p.93) and "sacrifice a male buffalo to the offered to Bishnu Bhagawan. A rooster was also given to him, also, a female goat and pair of pigeons were offered to the *mayus* and a bottle of liquor and a duck to Aghori Depot, the death-god". He also found *Panch bali* Sacrifice practices for health and well-being (Shepherd, 1982, p.91).

Baralmagar (2050 BS), also stated about Chandi, Pitri puja, Kul puja, Mandali, Bajubaraju, Mai, Bhairab, Nag Jhankari, Shikari, Mari, Bayu, Masan, Bhut, Siddha, Harelo and other god/goddess worshiped by the Magars for health and well being. They also worshiped Hindu gods and goddesses such as *Satyanaran, Ganesh* and so on (Baralmagar, 2050 BS, pp.128-133). In a different way, Thapamagar (2059 BS) argues that Magars were Buddhist followers. Further, he claims that Lord Buddha was from Magar ancestors (p.22). In ancient times, the Magars were Brijji. He also explained that after Hinduism spread out then declining Buddhism in south Asia; Magars compel to follow Hinduism. Furthermore, he argues that the Magars have remainder of Buddhist rituals in their culture and he gave the proofs in Magar culture and rituals (Thapamagar, 2059BS, pp.26-27). Similarly, Pun (2071 BS) argues that the Magars have a dilemma about religion and their religious identity as the leaders of Magar organizations, who raised these issues, couldn't provide their clear views. They also could not conduct academic discussions, communications. The leaders became instrumentalists, so, they gave religious definition and identity as per their own benefits. He suggests that thoroughly study of *kutumba* system among the Magars helps to clarify religion (Pun, 2071 BS, pp.177- 204)

2.2.8 Ill-health and Medication Aspects of Magars

Hamilton (1819) stated, "formerly, had priests of their own tribe called Dhami and seemed to have worshiped chiefly ghosts" (Hamilton, 2007, p.24) about the Magars, deities and worship for healings and well-beings. Similarly, Vansittart (1906) described "Magars and Gurungs are exceedingly superstitious. Most of the ordinary occurrences of every-day-life are referred by them to supernatural agency, frequently to the malevolent action of some demons. These Godlings have in consequence to the continually propitiated" (p.54) in ill-health and healings. Further he described, "among the minor Hindu deities, Diorali, Chandi, and Devi are those specially worshiped in Gurkha regimentOutbreaks of any epidemic disease, such as Cholera or Smallpox, are invariably regarded as malign visitation of Diorali or Devi" (Vansittart 1991, p.54) for health and well beings. Furthermore, he described an incident related to Cholera as:

In March 1889 a Gurkha woman died of cholera in the Gorakhpur recruiting depot. Every Gurkha officer, non-commissioned officer, and man at the Depot at once subscribed. The recruiting officers gave their shares, and with the proceeds, their goats, three fowl, four pigeons, and food of sorts, were purchased. Of these, one goat and the four pigeons were let loose, and the food is thrown away in the name of Devi, and the balance of animals was sacrificed to her, and then divided and eaten up. Before killing the animals, they all prayed together, "oh mother Devi, we will these beasts in thy name; do thou in return keep away all sickness from us". As no fresh case occurred, although there was some cholera about in the district, all the Gurkhas in the depot were more firmly convinced than ever that this was due entirely to their having propitiated Devi. (Vansittart, 1991, p.54-55)

Shepherd (1982), described an event as, "in 1965 an epidemic of Cholera swept through Nepal. It had reached a village called *Baghe*" near Yangchok, Tanahun. Further, he writes, "people from the surrounding villages had attempted to contain the plague by barricading the trails going to Baghe". When Major Nar Bahdur Thapa (Ex- Gurkhas) "broke through the barrier, the villagers all warned him to come back". After managing the Vaccine, Major Thapa returned to the village, at that time "the deads and dying were lying everywhere. People had fled to the forest and caves, abandoning livestock and relatives to their fate" and there were "twenty-two had already died" and he shouted to call villages to give a vaccine, people started to bury deceased, and "the rest he was able to save". About the prevention and cure of cholera, Gary Shepherd got the answer from the Major Thapa, "I took along garlic and kept a clove of it in my mouth at all times. Garlic fumes are able to kill cholera before they get into you" (p. 39). Furthermore, he observed the collection of the medicinal herbs and shrubs by Major Thapa and described as "often I saw him with some type of root, leaf, berry or bark that he was preserving. Later he would use it to heal some villager. He told me that he was familiar with a hundred or more different jungle medicines" and most of those herbs and shrubs used by a local shaman (p. 26). Similarly, about the view of Magars, he found as "the real Shamans had tremendous spiritual power. ..Their work was neither sleight of hand nor fake magic; their power was truly superhuman in origin" (p. 26). He also found shamans usually had a special drum in other areas of Nepal, but in Magar village of Arkhala he didn't see this and found beat the plate (p.98). In such a way, he described, "the Muthyar or healer, is also able to perform feats of magic, black or white. If he knows the proper spells, he can cause health or sickness and make others love or hate one another at will" (p.110). On the other hand, he stated, "when a pact between the demon and witches is made, the demon

becomes her *mechhoda*, a familiar spirit, If the witch wants to put a curse on someone or something, she will send her *mechhoda* off to perform the misdeed, if the object to be cursed" (p.174) and further stated about the healing practice as "someone got Sick, there was always at least one sacrifice to the giver to some deity or others" (p.109). In spite of that, he shared an experience as; "I was found through the years that the Magars had developed an extremely high level of endurance to all types of pain" (Shepherd, 1882, p.153).

Jiro (1974) illustrated, the soul of the deceased, who is unable to reach heaven, roam in the earth. These soul or spiritual powers give troubles for man and animals causing ill-health. The Shaman (lama) can neutralize these souls and spiritual power for health and well-being. The Magars have a religious belief in worshiping stone, trees, water, ancestor with offering alcohols and sacrifices on a regular basis. The local god '*Bhume*' is related to the ancestors of Magars and *Bhume* and shamanism are inter-related. The *Bhume* beliefs and tradition help to development of kinship and relationships for wellbeing. Further, he illustrated two kinds of myth of Shamanism. In the first myth, he described nine sister witches and nine shamans including Maite shaman of Galkun place. In the second myth, there are nine sister witches and Machhapurna shaman daughters and son of Garipurna. In the story, eight witch sisters were killed by gods, but one sister was able to survive. So, there is *boksi* and cause of illness. The shaman (lama) and witch (Boksi) have a mutual agreement in myth; that's why *Boksi* causes illness and the shaman chases using his incantation with giving *Patlo*. *Patlo* is offered for Boksi and Ghost in the crossroads. Shaman uses symbols of hunting and gathering age. The shaman heals doing conversation with god spirit and evil spirits (Jiro, 1974).

Watters (1975) described faith-healing rituals based on shamanism and animistic nature of Magar Kham speaking areas Rukum who "follow a transhumant pattern of life" (p.123). This is near to 'Siberian shamanistic traditions and Central Asia' (p.155). He stated, "the word 'shaman' comes originally from the Tungusic word *saman* meaning 'one who is excited, moved, raised, and borrowed into English from the Russian." (p. 123). In Magar Kham, it is said *Ramā* (or somewhere *rmā/armā*). The word '*Ramā*' is etymologically related to the Tibetan word *Rma-bya*. "The term is suggestive of the Kham-Magars shaman is a full ceremonial dress, covered with the feathers of the blue Monal Pheasant. In many areas, the indigenous term *rmā* has been replaced by the Nepali term *Jhankri*," (p.125). He stated characteristics of shaman as "the shaman calling, his relation with to the spiritual world, his initiation and instruction, his magic, his healing method, and so on, is of a particular type" (p.124-125). The Magar shamanism "lightly touched by the influence of Hinduism" (p.123).

Further, "the primary function of the shaman is magical healing". Because the "illness is for the most part attributed to the loss of human soul". Another main "shaman's task is to diagnose the cause of the soul's truancy, to capture it, and to re-establish it in the patients' body" (p.143). Similarly "there may be various reason for soul's absence-- it is either stolen away by evil spirits, it forsakes the body on its own, or it is aggravated from its abode by impurities and evil forces" and he described the healing stages by the shaman as " In the latter case, healing comes in two stages -- retrieving the soul, and purification of the patient. ...Often, part the treatment involves a sacrifice of some sort prescribed by the shaman to appease the evil spirits who have stolen the soul" (p.143). In addition, "three human souls or entities, the loss of any to which is sufficient to cause for illness" and these souls are *Syākwā*, *Sāto* and *Purus*. About the three types of soul he wrote:

The first of the three is known as *Syākwā* which "literally means 'flesh-cloth. Its loss is usually attributed to the work of an evil spirit of a witch, *Syākwā* assumes the form of a small packet consisting of bits of the patients' skin and fingernails, bound in a piece of the patient's garment and tied by several strands of his hair. The soul *Sāto*, often assumes the shape of an insect of beetle and such abandon the body.To retrieve it, the shaman calls on the help of his snake spirit, and "descends underground" in his search for it. When he finds it, he reintroduces it into the patient's body by calling on him to swallow. ..The third soul, *Purus* (from Sanskrit meaning 'person') is more closely associated with the real man than are the other two. To lose one's *Purus* is serious indeed, and usually means imminent death unless the shaman is able to retrieve it--a task he often fails in. To retrieve a *purus* involves a long and arduous journey on the road to underworld. ...When a person dies, there is always a danger that his *purus* may return and haunt the village. This haunting spirit is known as *Syuryāh* or sometimes *masān* (Watters, 1975, p.143).

Furthermore, "most shamanic séances are performed to diagnose illness and to effect its cure" (p.144). Further, he illustrated phases of the healing séance and "these phases are (1) the diagnosis and attempt to recall the soul from nearby, (2) the mystical journey beyond, and (3) expellation of the evil or impurity" (p145). Similarly, he has illustrated shamanism in Magar is tutelary and re-birth of shamans concepts. The re-birth or new shaman is examined by three senior shamans in *thumbu* ceremony on full moon day. He should climb *Suwā* (a fir tree); which was buried and erected in a ceremony place to pray god and announces the re-birth of shaman. They have own costume of shaman, shaman drums (Watters, 1975).

Fisher (1986) found an association between rituals and ill-health as well as well-being. He stated, "celebration of the local deities (there are also household deities and spirits) should be managed by a quarter of ritual specialist: Barphun, Naruphun, Sidin and Patum." He found such a specialist in Tichorung, but only *patum* in Tarangpur due to increasing active traders. There are Buddhist lama and two types of shamans, "one of animal sacrificing *Dhami* standard in this part of Nepal; other is *patum* who is a part priest". Part shaman; both perform rituals in *Kaike* and *Tibetan*, to guarantee purity and enters into states of spirit possession (p.24). Besides, "Tarangpurians worship their gods as shrines and natural objects, such trees, as well as at Buddhist and Hindu shrines and objects wherever they can find them.They acknowledge different god as having different powers in a different location; hence god are not in competition with each other" (Fisher, 1986, p.24).

Oppitz (1983) has described, shaman (*rama*) chanted the story of orphan girl *Barchhameni* in healing process. She was in slavery of the seven brothers who were witches and married seven witch sisters. A cow helps her. But, they slaughtered the cow and ate her meat. The *Barchhameni* did not eat. She buried all collected bones. From the buried bones, firstly bamboo grew, the birthplace of the first wild boar. The boar dug-out jungle soil and collected *medicinal roots and herbs*. He went to Terai to sell these medicines and buy commodities. After returning from there, a fight occurred in which all witches were killed. Then orphan girl married with wild-bore. Michael Oppitz also illustrated another version of the story which chanted of shamans in séances where boar is killed and roasted for meat and marriage held. However, all séances are done for healing and shamans chanted with a drum to cure illness (Oppitz, 1983). Similarly, Rex L. Jones (1976) has described four types of spirit possession in Nepal in '*spirit possession and society in Nepal*', which are 1) Peripheral Possession, 2) Reincarnate Possession, 3) Tutelary Possession, and 4) Oracular Possession. Among the classification, Magar's shamanism is included in tutelary possession (Jones, 1976, pp. 1-11) for healing.

Baralmagar (2050 BS) described a story of Shamanism (p.99) in the context of the Ghantu dance in the Magars where Dhyāngge lāmā and his nine sisters were qualified in incantation. One day there was a dispute between brother and sisters. The sisters won in incantation, therefore, the brother died. The sisters went for cremation with the corpse in the jungle, meanwhile, they met a hunter. He suggested burying the corpse with his drums and other utensils. They did so. Later on, the brother revived and his sisters disappeared. Those disappeared souls come into Ghantu dancer females. Hence he is relating shamanism, Ghantu folk dance in health and wellbeing (Baralmagar, 2050 BS). Similarly, Sinjali (2071) has

found Ghantu dance is formed for healing, health and wellbeing (pp.221-22). He also illustrated the traditional healing system, traditional healers and methods of healing (Sinjali pp.210-227). In such a way, Ghartimagar (2071) has described spiritual causes of illness and methods of spiritual healing. Moreover, Magar (2009) has illustrated an indigenous way of collection and processing of herbs and shrubs for medicinal purposes according to season. She found in a rural area, absence of allopathic and Ayurvedic health care system for locals and further she writes:

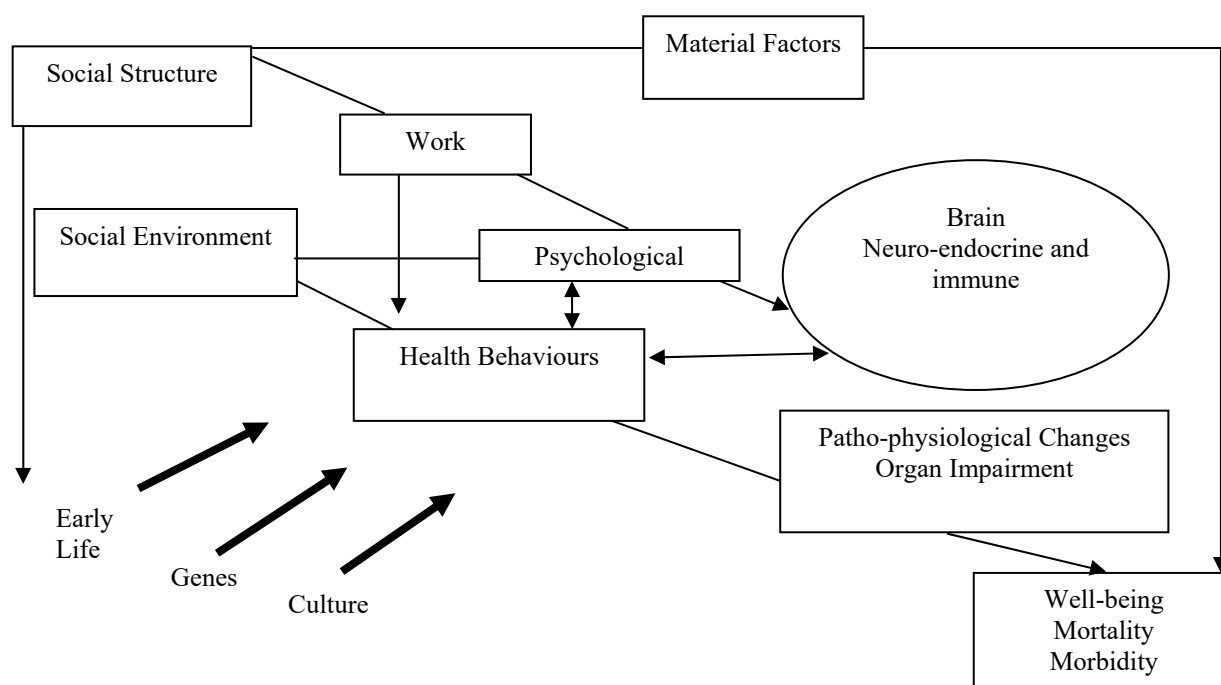
Most of the herbs have been collected by faith-healers who are using them to cure local people but do not have any idea of protecting these valuable resources. Interestingly, the survey has also shown that a majority of the respondents (66.1%) have been found to be using these herbs for treatment. Generally, people use tree barks, roots, and leaves of the herbs for their treatment of illnesses such as gastritis, bone fracture, muscle sprain, tonsillitis, irregular menstruation of woman, dog bite, snakebite, headache fever, sinusitis, stomach-ache, abortion, uterus prolepsis, and warding off the evil spirits from a person's body for good health (Magar, 2009, p.78).

2.3 Culture, Health and Society

2.3.1 Public health Care and Society

Marmot (2004) has analyzed the relationship between social inequalities and public health care. He illustrated a model of pathways of social influence on health in the article topic '*Social Causes of Social Inequalities in Health*'. He further stated, "In public health, our concern is not with economic performance, of which mortality may be an indicator, but with health status of which economic and social performance may be determinants" (p.37). In social policy and public health perspective there are not any conflicts; and "both of this purposed, health as an indicator and the determinants of health–social inequalities in health are important. In public health care, these inequalities are a manifestation of the social influence on health" (p. 37). He has illustrated the importance of 'social gradient' in analysis of public health care and social inequality. Further he stated, "In comparing the slope of the social gradient for different causes of death, we could focus on similarities or on the differences" and clarified "this social gradient in mortality is similar to that observed for morbidity" (p.39). He has been analyzed the linkage between income inequality and social inequality in public health care. He also argues that geographic and socio-economic

differences, environmental differences, social groups, social class, gene and early life, diseases of public health problems and public health uses are also playing the role of inequalities in public health care. He also discussed plausibility of causation and selection arguments. He also found mortality rate in some diseases is high in higher economic class and some diseases in lower economic class. However, choice of services may differ according to class, geography, individual behaviour, environment and so on. He illustrated causation of inequalities in public health care are poverty or economic inequality, Psychological or Material causes, social supports/integration, psychological environment for work, control/mastery, hostility, individual lifestyle, early life or current circumstances, biological pathways, social policy and medical care. Furthermore, he has described the model of pathways of social influence on health in public health care:



Model of Pathways of Social influences on Health

Source: Marmot, Michael, 2004, p.49

Wikler (2004) has illustrated personal and social responsibilities in public health care. In public health care, an individual has social responsibilities; but, individual liberties must be respected" (p.109). The "theme of personal responsibility has increased in prominence in health policy" (p.110). Further, he stated personal behaviour plays a role to intervention for prevention measures in so many health problems such as; HIV/AIDS, smoking and lung cancer, and both communicable and non-communicable diseases. Further, he writes, "the correlation of health and longevity with a social position—occupational and social status, educational level, and other indices of hierarchy—has been recognized for many decades, at least by the social scientist. In

recent years, this relation of the health to socio-economic stratification has moved to the center of public health concern" (p.113). He also argues the potential significance of personal responsibility for health as; "the first way to ensure that people do not burden others with the costs of care stemming from imprudence is to enforce rules requiring healthy choices" (p.112) e.g. wear seatbelt in driving, using helmet in motorcycle, etc. "The second element of health policy assigning responsibility for health to the individual would be the prospect that treatment for avoidable illness and injury would have a lower priority, or perhaps would be left untreated, at least at public expense"(p.112). "A third way of assigning personal responsibility for health, or the costs of treatment, would be to insist that the potential risk-taker pay in advance for insurance against added risk, either in the form of a user fee or a specific tax" (p.113). However, "the notion that people should bear responsibility for consequences of their voluntary choices makes up part of the bedrock of our moral and political culture". In addition, he has suggested, "In the field of health, personal responsibility can be life-giving. Because health and longevity depend so much on whether a person adopts healthy living habits, encouraging people to take good care of themselves is a key to a population free of avoidable infirmity and premature mortality" (Wikler, 2004, p.123).

Sen (2004), illustrated external and internal perspectives in public health care justice. Further, he stated, "Judgment of health equity, as well as aggregative health achievements in health care, are inescapably dependent on the assessment of individual states of Health" (p.263). The external perspectives have been described as 'observational oriented' subjects and further, he writes, "Public health officials often have no option but rely on external observations" and used "externally observed medical statistics" (p.263). He has argued, external perception of illness and health is observed by the doctor, health worker or an outside expert. And internal perspective has been described as 'perception oriented' where studied *self-perception* of patients and collected perceptual information and further he wrote, "Illness and pain are rooted in the person" (p.265). He also described the limitation of both methods to use in illness and health and has given an emphasis on the use of both 'internal' and 'external' perspectives for judgment of ill-health and health care in public health. Furthermore, he has given the example of Kerala state of India where the highest rate of morbidity reported, but life expectancy is higher (74years male and 76 years for women) than the Indian average life expectancy of 64 years. Bihar and Utter Pradesh of India have a low rate of morbidity reported but low life expectancy in public health or medical authority reports. This means internal views of patients, an endurance of pain and disease is influenced from social causes as; achievement of education, awareness, availability and accessibility of medical care.

Statistically, Bihar has a low morbidity rate but there should be socially situating self-perception of illness which wasn't recorded applying internal perspectives (Sen, 2004).

Kleinman (2004) has illustrated health inequality from the issues of health rights and ethic discourse in public health care. He examined this issue from an ethnography perspective in the field study of China. He described ground reality of human living, status, resources, transcendence experience of survival, cultural and social differences (differences in gender, age cohort, class, ethnicity, religion, individuality) and interaction with these local worlds creates the moral. The "illness and suffering (and responses to it) is part of what defines local moral words" (p. 270). The "moral experience is always about the practical, engagements in particular local world." The "cultural space that carries political, economic and psychological specificity—a view from somewhere and actions and reactions that are partisan—ethical discourse is globally, elaborated abstract articulation of and debate over trans-local values" (p. 270). He suggested that, "the relationship between moral and the ethical should be at the heart of efforts on behalf of health equity" (p.271) in public health practice. Further, he writes:

Local world is, among the other things, also the ground of social experiences of health, suffering and health care. What is at stake for patients, family members, and professional health care providers in particular localities defines one side of health rights and responsibilities: we might call this side, following the ethnographic terminology that I have put to use, moral process. These same moral processes incarnate the inequities in health status and in the distribution of health care resources that is the source of concerns about health equity and social justice. The other side is an ethical discourse, which, as I have defined it, is universal, or at least aspires to be translocal. But to apply ethical discourse, in this instance concerning equity and rights, we first must do it in local worlds in at least two senses first ethical discourses in appropriated and engaged by members of Local world. Second, ethical deliberation about and engagement with particular local realities occur among ethicists who themselves are often a member of the other worlds, .. bring his or her local world and its moral process with them into ethical deliberation. ...that is to say, we must develop transparent strategies to translate ethics into local worlds, and to take into account both global and indigenous ethical points of view (Kleinman, pp. 274-5).

In addition, Kleinman (2004) further illustrated, "Suicide in China raises important questions concerning Health equity and health right" (p.276). In addition to that, he describes gender inequality, rural-urban disparities in health and social conditions, a gap between rich and poor,

worsening social and health inequality, epidemic violence, substance use, depression, sexually transmitted disease including HIV/AIDS, family breakdown, etc causes of local world for increasing suicide in China. These public health issues, which have drawn the attention of the Chinese government, women's associations and media. And finally, he concludes:

The interaction between the moral and the ethical aspects of health matters also will not in and of itself resolve serious issues of health equity and human rights; at best all it can do is create the conditions in which those issues are more validly grounded in actual human conditions so that the moral and ethical burden of responsibility of policy-maker, program directors, and professionals and laypersons is made unmistakable, even while potential outcome of engaging those issues of equity and rights remain as uncertain as is the rest of social experience (Kleinman, 2004, p.280).

Acharya, Regmi, Simkhada and Teijlingen (2014) have explored the issue of sex and sexuality in public health care. They argue that, "issues of sex and sexuality have become major public health concern" due to HIV/AIDS spread out as an epidemic and other sexually transmitted infections (STI). Therefore, there is a "need to identify people's attitude, beliefs and behaviours towards sexual and reproductive health" (p.66). Although in Nepal pre-marital and extra-marital sex is not accept traditionally. In contrast, in Nepal, 40% males, 10% school-age adolescences, 15% young boys have experience of pre-marital sexual intercourse. The 1% women and 3 % men had two or three partners in the last twelve months of the study date (p.68). In early studies, 24.1 % males and 14.9% females engaged pre-marital sexual intercourse (p.73). The "pre-marital sex have increased for young people due to delay in marriage caused by young persuading educational and employment goals" (Dahal 2008, Cited in p.68). There are also found increasing dating and pre-marital romantic partnership in Nepal (pp. 76-81), extra-marital romantic partnership (pp.81-82). These were consequences of modernization, information technology, urbanization and migrations, social causes. They also indicated increasing adolescent pregnancies, low use of contraceptives, unsafe sexual behaviours, abortins are emerging public health issues in reproductive health, HIV/AIDS and STIs (Acharya, Regmi, Simkhada and Teijlingen, 2014).

Kristvik (1999) studied public health care of Nepal specially, rural area Bhojpur from the medical anthropological perspective. She found, "the national public health system predominantly based on the western medical system, frequently called bio-medicine" (p. 82). There are also other medical traditions as; "the ancient Ayurvedic discipline, can also be found in the national public health service. One of the nine health posts in Bhojpur is

supposed to Ayurvedic" (p.82). The "public health care services are fairly new to Nepal's rural areas. Until the health post system was introduced in the 1950s, the Nepali villagers relied on the shaman, herbalists and bonesetters for assistance in health matters" (p.69). Further, she mentioned, "practical obstacles and lack of information about the public health services have been used to explain the underuse of the services" (Kristvik, 1999, p. 69).

Pati and Harrison (2001) illustrated public health, medicine in colonial India. The writers described the new medical market (p.9) in India under the colonial rule of western-style medicine in the seventeenth, eighteenth and twentieth centuries. However, "Ayurveda (Hindu) and Unani (Islamic/Graeco-Arabic), that of folk practices such as bone setting have been largely neglected" (pp.9-10). He argues that Ayurveda Medicine was taught in a scientific way and practiced in diversified medical (medical pluralism) in India due to the influence of western medicine. Moreover, the western-medicine has increased the colonial power and political power of the western rulers (p.13). Besides that, there was a Christianity expansion strategy via bio-medicine around the world (pp.88-137). There was a degradation of the Unani medical system (pp. 317- 355). He also illustrated public health care system and development of medicines in contemporary politics, a situation of indigenous medicine practices, religion and medicines, culture and medicines, medical markets and development of colonial India (Pati and Harrison, 2001).

Harper (2014) has illustrated formal public health care (bio-medicine) and informal health care (traditional) in the context of the Palpa district of Nepal. He has critically examined their implication, practices, consequences, power and politics in health care. He also analysed tuberculosis (TB) preventing program and Vitamin- A program, United Mission Hospital provided training for *lāmā* (shaman) in public health care. But, allopathic practices at a local level, there was the birth of a new shamanic pharmacy. Further, he writes, "each case highlights the aspects of public health and medical practices; of the influence of globalization and its politics; of the fragmentation of primary health care goals in light of the verticalization of programme; and consequent 'pharmaceuticalisation of public health' (Biehl, 2007) in the context of rising private-sector expansion" (p. 3). Furthermore, he found, "ever-increasing presence of pharmaceuticals and pharmacy retail outlets, allopathic health workers and health programs which form the grounds through which everyone now has to engage with being ill" (p.69). Beside this, he also examined the health care service provider of public health of the district, where politics and power influencing in public health care (Harper, 2014)

2.3.2 Socio-cultural Aspects of Health

Rogers, Baral, Sharma and Stephens (2015) studied the customs and beliefs in newborn babies' care. They argue beliefs and customs of a community could increase or decrease the newborn baby's health. Some custom and believe of the community could be scientific and helpful to a newborn baby and some might be unscientific which degrade the health. There are so many variations of indigenous ways of custom and believes in newborn baby care in different caste/ethnic groups. But, "many of the customs are based on Hindu and Buddhist religions..... Nepali following variety of customs and traditions" (p.17) regarding newborn baby care. They also observed socio-cultural factors influencing child mortality and morbidity. Moreover, "poverty in Nepal is a factor dictation the poor health of many and endured by about 60 percent of the population, most persistently a rural phenomenon" and "there is not enough time the day to walk the distance to the health facilities and do not have the money to pay if they attend the health facility" (p.19). Further, they also argued women are subordinate in the rural area and lowest position for new daughter-in-law. Therefore, they should do physically hard works and limited choices of health facilities during pregnancy and in giving birth. The knowledge of mother-in-law regarding subjects of health and hygiene in newborn baby care is limited. Similarly, after birth delaying cutting the umbilical cord and waiting for the time of placenta out, bathing for newborn baby, delaying breastfeeding increase risk of asphyxia and hypothermia. In rural, umbilical cord management using a dirty sickle, topical use of 'cow dung or buffalo dung' in umbilical cord using tradition also increased health risks. Discarding the first milk (colostrums) due to believing 'witch milk' cause loss of nutrition for newborn baby. Amulets and bracelets are given to the newborn babies to protect them from supernatural powers; using kohl to lining the eye to protect from eyes infection also the traditional customs in rural areas too. The governmental effort is to continue in improvement of newborn babies' health and women health (Rogers, Baral, Sharma and, Stephens, 2015).

Adams (2004) analyzed the socio-political impact on culture and ethno-medicine of Tibet. Tibetan indigenous medicine was based on the epistemological foundation of Buddhism. He argues "health is a product of social, economic, political, and religious social structures that are themselves shaped and constituted culturally and in contested political terrain" (p. 283). Tibetan medicine illustrated "a harmonious relationship between being and environment are the three humours: Wind (*rlung*), bile (*mkhris-pa*) and Phlegm (*bad-kan*)" (p.299). Further, he mentioned, "When the humors are functioning well, the body's waste products emerge in perspiration, faeces, and urine. They also ensure the refinement of ingested products into the

seven bodily constituents; chyle, blood, flesh, fat, bones, marrow and seminal fluid" (p.299). Further, he illustrated basic theory of anatomy as, "anatomy links the material and spiritual worlds in complicated relationship between the five elements (believed to make up all phenomena) and the forces of consciousness that enable the elements to take a specific form in, say, a human body" (p.298). These five elements are wind, earth, water, fire and space. The wind is responsible for movement, the earth is responsible for giving substance, fire responsible for transforms or 'cook' things, and space provides the place where things can exist. There was a concept of rebirth and "rebirth is contingent upon the type of winds circulating in the life-force"(p.298). Further, he argues, "Tibetan ethno-medical perspective privileges a view of sickness that points to the cultural and social dimensions of health and health equity" (p.284). However, "both science and Chinese socialism insist on a radical materialism that separates religious 'belief' from objectives 'facts' when it comes to health issues"(p.291). Thus, he argues, "Tibetan medicines, social conditions that are not conducive to eliminating the poison are seen as indirectly pathological—as disease-producing" (Adams, 2004, p. 299).

Ingstad (1990) illustrated cultural construction of HIV/AIDS disease, healing and prevention perceptions and practices in Botswana. The researcher stated the role of a traditional healer in Botswana as the "most important carrier of Tswana Medical tradition. Yet, their views and practices are not static but are under constant influence from religious and cosmopolitan medical sources" (p. 28). In Botswana, the first case of AIDS was reported in December 1985 and screening for HIV was started in November 1986 (p.29). In Botswana frequently found Tswana healers is *ngaka ya diatola* (doctor of the bone) who use to a divine set of bone and herbs, and *ngaka ya dishotswa* (doctor of herbs). They are also called in short *ngaka* and in plural *dingaka*. Similarly, there are increased Prophets in churches as traditional healers. About the traditional healers, the researcher mentioned as:

In old days, *dingaka* had a close relationship with tribal leaders at different levels. The chief knew every *ngaka* within his region and would call upon them for various purposes—as healers, advisors, religious specialists, and assistants for throwing the bones to find the guilty party in case of witchcraft accusations. The *dingaka* were also seen as intermediaries between the living and the ancestral spirits (p.31)

The "Tswana medical beliefs focus on the origin of the medical condition but also incorporate another type of misfortune with the conceptual system. Aetiology concerns two levels of causality: the origin and immediate cause" (p.32). Further, "at the level of origin, there are main causes of sickness and other types of misfortune: witchcraft, ancestors, anger, and pollution

through breaking taboos. These causes are mutually exclusive explanations of symptoms and may be divined by the *ngaka* through bones"(p.32). The immediate cause of sickness is blood, and blood is seen varies as disturbances as 'dirty blood', 'high blood', too much or too little blood (p32). The researcher found that there was a culturally constructed different explanation of AIDS to understand and to fit into the Tswana medical explanation system. The concept of transmission of AIDS is connected to the concept of pollution originate in the female body. This type of pollution is transmitted to the men through sexual intercourse which was done "culturally proscribed periods after birth, abortion, etc. and before ritual purification has taken place" (p.33). "The man, through sexual intercourse, may then transmit the pollution to other women. Pollution that is caused by such violation of sexual taboos is called *melia*" (p. 33). In Tswana medicine, *melia* caused disease *mopakwane*, "which may afflict small children with general weakness, apathy and eventually mentally retardation or death". For this disease, a husband should have intercourse with his wife before three months of birth, or after doing healer purification rituals. Similarly, in the present understanding *melia* is seen in both male and female bodies called *boswagadi*, and that *boswagadi* leads to death. In Tswana culture, *boswagadi* disease represented to AIDS and traditional healer could not cure. Furthermore, the researcher argues, "although from a biomedical point of view healers probably cannot cure AIDS nor influence the course of the disease, their beliefs and practices still have important consequences for prevention" (Ingstad, 1990, p.37).

Wasti, Simkhada and Teijlingen (2015) have illustrated socio-cultural aspect to prevent HIV/AIDS which is called locally as *thulo rog* (big disease), *Saruwa Rog* (infectious disease), Mumbai or foreigner disease, *naulo rog* (new disease), a fatal and final disease. They argued there are difficulties to prevent HIV/AIDS in Nepal due to socio-cultural causes. Further, "people's capacity to deal with the threat of disease is fundamentally shaped by the socio-economic and cultural conditions in which they live. Socio-economic variables can be both determinants and consequences of HIV and AIDS" (p. 53). In Nepalese culture, "dealing with sex issues in Nepali society is regarded as disrespectful. Sexual behaviour is not openly discussed in Nepal and talking about sex is considered impolite". Therefore, "the existing socio-cultural frameworks of Nepal do not provide an environment for safe disclosure of any person who is HIV infected" (p.53). Furthermore, "The gender gap is huge because of women's lower economic and socio-cultural status; women and girls are disadvantaged in negotiating for safer sex and accessing prevention information and services" (p.53). Rural poverty compels migration for searching job opportunities and a better economic situation. The migrated labours bring HIV infection for rural women. There is also family separation due to poverty which is a

cause of encountering multiple partners both male and females. Poverty and inequality, geographical rural and inequality in development, culturally marginalization are influencing insufficient health care, buying health care facilities. That's why there are challenges to prevent and control HIV/AIDS in Nepal (Wasti, Simkhada and Teijlingen, 2015, pp. 47-62).

Whiteford (1997) has illustrated the public health concerned disease dengue from ethno-ecological and ethno-medical perspectives in Dominican socio-cultural settings. Dengue is a communicable viral disease transmitted by female *Aedes aegypti* mosquito (vector) and these mosquitoes grow in water of flower pot, discarded automobile tires, and water storage vessels. It is a tropical disease and it becomes fatal in dengue hemorrhagic fever (DHF) or Dengue Shock Syndrome (DSS). Dengue is a public health concern and public health issue because the illness could be spread out epidemically at any time. So, it is "more dangerous from a "public health standpoint"(p.207). The researcher has described a perception of an indigenous typology of water ethno-scientific understanding of water quality, source, and uses such as brackish water, sweet water, purified water, safe water and their different use purpose and storage (p.212). Moreover, "this typology of water use demonstrates a hierarchy that reflects the constraints of scarce resources (such as money or labour) on the acquisition of water" (p.213). There is a gender role in the collection of water and handling; especially "the role of women as domestic managers of water collection, storage and use" (p.216) for health. About dengue both ethno-medical and biomedical model researcher found that "(1) it was dangerous for those whose health was most vulnerable (*debil*), such as babies; (2) it was transmitted to human through mosquito; (3) mosquito bred in garbage and deposited their larvae in water; and that (4) communities alone could do little to protect themselves from dengue fever" (p. 214). Although most of the respondents said mosquitoes transmit Dengue but some respondents were believed on Gusarapos (larvae) of water responsible for infection. Similarly, to prevent dengue local practices were cleaning water depositing places and pots, fanning air near water stores and blow them away; and for control, they use commercial pesticides. However, they have a strong believe to control dengue is difficult to create mal-union or lack of political will (p. 215). Researchers found that ethno-medical understanding of the reproduction of *Aedes aegypti* mosquito is overlapped with biomedical knowledge (p.218). In addition, they have stated, "ethnoecological analysis suggests that gender roles, community cooperation, and perception of one's social and physical environment are significant of water handling" in dengue case. The "ethno-ecological perspective is that it bridges the medical ecology and political ecology model. The development of ethno-medical

models is a good descriptive and analytical technique for gaining insight into how people perceive their surroundings and organize information" (Whiteford, 1997, p. 219).

Singer, Davison and Gerdes (1988) studied the reproductive illness behavior in the local cultural setting of Haiti. In the local socio-cultural setting, frequent reproductive illness was *matris deplase* (displaced uterus), *Lamne tonbe* (fallen uterus) and *grann chale* (vaginal burning), and cultural bound syndrome illness experienced by the women are *pedisyon* (related to vaginal bleeding), *emoraji* (related to bleeding disorder), and *pedisyon-fibrom* (illness related to uterus mass); which causes weakness, infertility, a disorder of reproductive health on their socio-cultural beliefs. Traditional healers of Haiti are *houngans*, *mambaos*, *malfete*, *dokte fey* (herbal healer) and *fanm saj* (midwives) who are skilful at working body, spirit, therapeutic plants and ritual performances. The interpretation of reproductive illness is based on their culture and IKS. However, both traditional healers and laypersons are known that *pedisyon-fibrom* illness could cure by bio-medical doctor. Further researchers wrote:

"We found in our observations of and interviews with medical professions in Haiti a tendency to discount the ideas and understanding of their patients as irrational, backward and irrelevant, It appears, is based on assumption that indigenous health beliefs are static and stagnant and hence inherently in conflict with medical system alleged to be found on the scientific principles of empirical verification and accumulated knowledge (Singer, Davison and Gerdes, 1988, p.381).

Hagen (2070 BS) had listened to about the *Bhut* (ghost) and *Rakchhes* in hill and Himalayas. One day he travelled in Gandaki riverbed in May of 1954, his porter became fainting a long time due to hot climate and he gave allopathic injection medicine. Meanwhile, his porters show him to the shaman. He sacrificed chicken. Later on, he woke-up. But, his experienced porters were claiming that there was a ghost in their camp area that's why he became ill. They have strongly believed that he was able to wake-up due to sacrifice and propitiate to Ghost. There was a belief in spiritual power and cause of illness; worshiping and sacrificing needed to cure from illness. The shaman could help to chase away evil power and propitiate the spiritual power for health and wellbeing in Nepalese culture (Hagen, 2070BS, p.17).

Gurung (1980) has stated shamanic culture, religious praying for well-being in Devghat on the occasion of Maghe Sakranti. He wrote, "here was a group swaying in religious chant, there is another group singing folk tunes and further beyond due to song in full swing. The rhythmic beat of the Jhankri drum reverberated in the forest night and diversity of sound and variety of light gave an air of carnival to the scene" (Gurung, 1980, p. 251).

Maskarinec (May, 2012) has described a need of Socio-cultural aspects in studying health and illness, indigenous practices from the medical anthropological perspectives. He has argued, "Shamans continue to fill important diagnostic therapeutics and conflict resolution roles in western Nepal" (p.22). Nepal has gained a lot of changes in political, social and cultural, and health care. However, traditional healings, practices, the concept of fortune and misfortune, shamanism are in a central role in Nepalese health care but Nepalese sociologist and anthropologist are not portraying these social phenomena. Similarly, he argued that in shaman oral text, there are exploring inequalities of political power and power abuse, socio-cultural status, caste inequalities, women status, exploitation and a wide range of social issues of Nepal (Maskarinec, May 2012).

Adams (1998) has described the role of health professions in Nepalese politics (Specially, in revolution of 1990/ *Janaandolan*). They were motivated for involved in politics due to social inequalities, hierarchy, corruption and dissatisfactions, politics and politics in medicine. She has illustrated modern individual, modern deviance, modern truth, modern concealments, modern objectivity for medicine, science and democracy in the Nepalese context (pp.15-29). She also mentioned Nepalese history and power, ethnic diversity, cultural diversity and inequalities (pp.30-81) to grow anti-*Panchayat* regime movements. She has found revolutionary views "political solution to medical problems demanded political action (p.3) among the health professionals who took part in the revolution. She has serially described movements which were held in 1990, the doctors and health professional supports, black armband strikes, protest on the road with a white coat, arrest events of health professionals, casualties and deaths in movement, medical supports for casualties, grass-root health workers role in revolutions (pp.82-141) which was played a vital role in to gain democracy. She argues, "the linkage between democracy and medical science was for many Nepali professionals based on two ideas: the first was that truth could be universal because objective and the second was that objective truth was constituted in a realm that was distinct from that of religion" (p.8). Similarly, she argues the main motivation factors (pp.142-159) to attract in revolutionary activities for health professional was "weariness of corruption and the repression provoked was a principal motivation for revolution among Nepalese in general and fighting against". Moreover "most urban medical professionals articulated through several positive agendas: the desire for an end to social inequality as a basis for an end to health inequality, and the belief that ending social inequality began with creating a true political democracy" (p.143). However, she also argued that all health professionals had not the same motivation factors. They had different factors, interests and desires in different level's health workers and individual medical professionals. She has an analysis about the theories and

practices in different countries of medicine and politics, compared with the Nepalese revolution context and how it is applied in political change (pp.160-181). In such a way, she found "while a politicized medicine enables these professionals to help provoke and sustain a revolution for democracy, their desire to constantly politicize medical truths also became a source of some tension for the professionals in the years afterward" (p.7). Post-revolution, there was not decreased corruption, nepotism, source and force, elite class suppression, discrimination of ethnic/castes and social inequalities. But, there was an increasing gap between followers of different parties (government and opponent party followers) which give birth to conflict within medical professionals (p.199). She also mentioned increased number of new medical NGOs and politicians using NGOs for their vote attraction in the communities. She also found professional policy affect the ANM (assistant nurse midwife) and other junior health workers in getting higher qualifications (pp.195-98). Medical education has been expanded post-revolution but accessibility was for elite higher caste. Besides this, the government has established health sub-post in villages, simultaneously increased private sectors. Furthermore, she found political privilege of democracy as, "perceptions that traditional Nepali culture should and could be preserved under democracy focus on its rich religious heritage, its tolerance for ethnic and caste pluralism, its family values, and its nurturing of the social and personal dimensions of social life over the technocratic or bureaucratic demands of industrialization"(p.228). However, political change all the expectation does not fulfil in medical care, but politics in medicine has been continued (Adams, 1998).

Hollins (2006) argued that to provide effective health care with respecting an ill person's dignity, a health professional should understand multi-cultural and multi-lingual environment, and existed religious faith of the society. So he writes, "within health care environments, where patients are naturally vulnerable, our greater understanding and appreciation of different cultures will deepen our pastoral care as well as our clinical care" (p.2). To understand the different elements of culture, the writer suggests as, "the image of an onion, with many layers, has been used. The different layers illustrated the ways in which culture influences our lives, from implicit to the explicit"(p.2). Moreover, "different cultural traditions also influence the way in which an individual will respond to illness and to treatment" (p. 6). The writer also indicates different language and cultural difference in language affects in the interpretation of illness and health care (p.5). So, "the establishment of trust is crucially implicit in all relationships between healthcare staff and the patient" (p.7) in a multi-cultural and multilingual environment. "A religion is a system of faith and worship, both of which express spirituality" (p.9). The further writer argued, "although a spiritual or

religious belief and practice is regarded as intensively private, belief is never entirely self-generated. ...Thus it is more accurate to talk in terms of common religion rather than a private one" (pp.10-11). The writer clarified as, "In any consideration of both cultural diversity and spiritual care within health care provision, it becomes evident that we have embarked upon what might be termed as reclamation of the individual—a creative recognition of the person who is the heart of any treatment" (p.18). Furthermore, the writers have given information about background and belief, names/naming, religious obligations, diet, dress, language, birth, personal hygiene, Gender, privacy and dignity, attitude to illness, blood transfusion, contraception, fertility treatment, visiting, dying and death, post-mortem, organ and tissue transplant elements of care of every religion e.g. Bahai, Buddhist, Christian, Others (Christian Science, Jehovah's Witness, Mormon (Church of Jesus Christ of Latter-Day Saints), Rastafarian), Hindu, Islam, Jain, Jewish, Pagan, Sikh, Zoroastrian; which are in practice in UK (Hollins, 2006)

Similarly, Gurung (08 Bhadau, 2067BS) discussed suicide illness and socio-cultural causation in the article 'Atmahatyako Samajshastra' in the Kantipur newspaper. In his article, he has presented statistic of suicide and technique used by who committed suicide in Nepal, and further he supported Durkheim's suicide theory and interpreted in Nepalese context. He has argued that causation of suicide entirely social therefore improving society, social norms and values, and by implementing socio-cultural ethics, suicide cases could be reduced in the society (Gurung, 08 Bhadau 2067 BS, p. 7).

2.3.3 Ill-health and Medication Practices

Hamilton (1819) described illness and medication of Nepal in his Nepal visit at 1803-4. He found, "the inhabitants had been much troubled with fevers, and for the first three months after our arrival, the whole of our native attendants were exceedingly sickly" (p.66). Further, he writes,

"The complaints to which they were chiefly subject, were fevers of the intermittent kind and fluxes, attended with a very copious secretion of slimy matter, which by the natives, is attributed to Bayu or wind; and which was brought on by very slight indulgences in eating. In the fevers emetics seemed much more efficacious than the cathartics which are usually employed at Calcutta; and, indeed, a dose of emetic tartar very frequently cut the fever short, as usual in temperate climates. The fluxes were not attended with much pain and both these and tendency in the bowels to the slimy secretions seemed to require the frequent exhibition of spirituous bitters and small

doses of opium. In such cases, I found the *chirata* tolerably efficacious, but I thought others bitters more powerful, specially the infusion of chamomile flowers and the compound tincture of Gention and Peruvian bark. I have seen no country where the venereal disease is so common as in Nepal, nor so generally diffused among the classes of the people, who are indeed very dissolute. During my stay, I had an application for medical assistance from all ranks labouring under the venereal disease; and I observed that the men did not consider it as extraordinary or shameful when they found their wives afflicted with this malady (p.66). Cutaneous disorders, and specially the itch, are also very common, and almost as prevalent as in Hindustan. Leprosy, in which the joints drop off, is as common as in Bengal; but in Nepal, it cannot be attributed to the lowness of the country, nor a fish diet, to which the people of Kathmandu have little no inclination. Some of the persons afflicted with this horrid disorder, I found to be of considerable rank, and quite removed from the want of nourishing diet (Hamilton, 2007, p.67).

Similarly, he found the concept of leprosy as "the natives consider the disease as hereditary" (p. 67). About goitre, he found "swelling in the throat that is common among the inhabitant of the Alps, prevails in Nepal, and, indeed is frequently seen everywhere north from Patna" (Hamilton, 2007, p.67).

Kristvik (1999) illustrated traditional beliefs of relevance to the symptom of Tuberculosis (TB). The Bhojpur district had an influence from Hindu cosmology. There is "intimate connection between microcosmos and macrocosmos is the basis for the astrological science, central to understanding of sickness and health in Bhojpur" (p. 49) regarding TB. Therefore, there is taken cause of disease for unfavourable planetary constellations—*Graha*, *Dasha*, *Dinko Dosh*. Similarly, there was a concept of 'the balance of hot and cold' to maintain health and wellbeing. Loss of soul (*Sato Haraunu*), attacked by god (*Deutako Dosh*), House Gods (*kulpitra*) also cause the illness. The *Rai* ethnic group had a strong belief on house god (*Kulpitra*) as a cause of disease. Traditionally, they worship the fireplace (*Chulha*) as *kulpitra* which isn't touched by other caste groups. If someone touched, understood as unclean, the *Kulpitra* could angry and cause illness. In such a way, there were beliefs in witchcraft, Sorcery, and the evil eye (*Boksi and Akha*), Hungry Ghosts and Restless Spirits (*Bhutpret*) to cause illness. In such a condition, the locals take the help of a shaman and ritual experts to heal the illness and wish for good health (pp. 46-77). Furthermore, she has also illustrated cultural construction belief model, social stigma about TB (Kristvik, 1999).

Gartoulla (1998) illustrated ill-health and medication from ethno-medicine perspective in the Nepalese cultural context. According to him, Nepalese were using plants and herbs in medication all over the country. Further, he argues "even a casual observer of ethno-medicine and therapy will not fail to notice that plants play a large role in the formulary of ethno-medicine in Nepal." Moreover, he writes, "Trees worship is not uncommon, and the root of such veneration may be unearthed if scientific studies are made adequately and without much further delay" (p.78). He has pointed out the problem of terminology (Taxonomy) for anthropologists/ Sociologists to describe ethno-medicine (p.79). If someone became sick, he can be treated through any one or more means as "i. propitiation of gods and goddess; ii. propitiation or driving away from the evil spirit(exorcism and witchcraft), iii. treatment by magic; iv. use of charms and amulets; and v. application of empirical medicine- (a) western medicine (b) ethno-medicine" (p.80). Moreover, he has illustrated medication practices of varieties of 92 illnesses existing in the Nepalese society and culture, as a ethno-medicine practice (pp. 83-117). Similarly, he stated supernatural causation of illness as, "(1) Wrath of gods and goddesses including unfavourable planetary effects; (2) Evil Spirits; (3) Sorcery; (4) Witchcraft and evil eye; and (5) Breach of Taboos" (Gartoulla, 1998, p.126).

Budhathoki (2011) illustrated ill-health perception and medication practices among the Local people living in *malaria*-endemic villages of the central hill region of Nepal. According to him, "fever is a common illness as well as a symptom in rural areas. It is perceived to be influenced by numerous factors"(p.125). He also found, "local people perceived fever as illness induced by several illness and conditions such *dagdi* (exertion), *aulo* (malaria), *dokh* (typhoid), flu, throat pain, pneumonia, evil spirits, *Nepale deuta*, measles, chickenpox, weakness walking or working several hours in a hot day" (p.125). Further, he reported *Jwaro* is called in Nepali and *Chhawah* in Tamang language for fever. According to local classification, *Sardiko Jwaro or rugha kasno ko jwaro* (common cold/flu), *Dagdiko Jwaro* (fever of exertion), *Aulo Jwaro* (malaria), *Dokh* (typhoid), and *Lagu/Laganiko Jwaro* (fever due to evil spirits). In such a way, he found medication practices as, "headache, body-ache and fever are self-treated by taking anti-analgesic and antipyretics tablet such as paracetamol (locally known as cetamol), which are easily available in tea/retail shop of the village" (p.132). The "paracetamol and ibuprofen (pain killer) tablets are used to relieve body ache, headache and fever" (p.132) by themselves. "There is a common perception that *dagdi* (fever of exertion) recovers itself within few days without any specific treatment" (p.133). He further explains, Local people avoid certain foods such as curd, meat, egg, oily and spicy food during fever illness of *dokh* and "they usually drink plain hot water of boiled with black paper of

turmeric powder, or ginger and holy basil leaves in fever induced by common cold" (p.133). He also found, the *Danuwar* ethnic groups have indigenous treatment practice as "prepared juice by crushing root of *Archal plant* and leaves of *BokeJhar*" (p.133) for *dokh* fever. They have belief if someone took curd or egg when s/he suffering from *Dokh*, it became worse. In this situation, they have believed in folk medicine as taking half-ounce ash of burning curd and egg which helps to cure. If herbs and folk medicines do not cure the disease, then they go to private or governmental health institutions. He also pointed out the perception of febrile illness caused due to evil spirits could not be treated by modern medicine and needed *Dhami/Jhankri* or *Janne Manchhe* to remove the cause. In this case, the evil spirit should be warded off before taking medicines. Further, he found *Tamangs* have *bomboo* (traditional healer) who perform a sick ritual, sacrifice chicken to chase away evil spirit or propitiate demon or gods for healing and wellbeing. In such a way, he further argues, the local classification febrile illnesses: *Sardiko Jwaro* or *rugha kason ko jwaro* (common cold/flu), *Dagdiko Jwaro* (fever of exertion), *Aulo Jwaro* (malaria), *Dokh* (typhoid), and *Lagu/Laganiko Jwaro* (fever due to evil spirits) have cultural meanings (Budhathoki, 2011).

Subedi (2011) has discussed Newars' understanding of illness aetiology in multi-causal which are individual, social, natural and supernatural causes and causes are interrelated each other of Kirtipur. He found most of elderly peoples believe in vital force *Shakti*, who balanced the universe, and god is power of source. To propitiate the god should be performed rituals and do sacrifices (pp. 104-5). Similarly, there was a "concept of 'strong health' and 'weak health'". It was also linked with the health of the mother. "The belief that the strength and weakness of a baby depend on the nature and function of the blood of husband and wife" (p.105). Peoples broadly categorized the causes of disease into Natural and Supernatural causes. They were also aware "A poor diet, wrong food, too much smoking and drinking, poor-housing and sanitation condition, lack of money for food and clothing" also caused the *rog* or disease (p.105). In addition, individual careless in diet, clothing, hygiene, sexual behaviour, physical activities and all aspect of personal behaviour can cause illness. In such a way, the natural world also causes the illness such as; bad natural environmental situations; air pollution, water pollution, climate changes or bad climate (extreme heat and cold), parasitic infestations can cause the disease. The local Newars also believe in supernatural powers God, goddess and evil spirits, witch (Boksi) and Boksi Ankha (evil eyes), Bhut prît, Rakshes, demon, which cause illness. These are also responsible to fires of houses, blight crops, barrenness to wives; bring disease and drought in the community. He found, "the elderly people classify the god and goddess, demon, *Bhut* (ghost), *Pret*, *Masan* and *Bayu* as supernatural beings. The

notion of the *Shakti* (power) is the defining characteristic of supernatural beings" (p.111). The supernatural causes of illness can be cured by the *Dhami, Jhankri or Janne Manchhe* and ritual worship (*puja*) for the powers (*shakti*). He also illustrated local perception of mental health and health-seeking with worshipping god and goddess, visiting local faith healers and psychiatrists; biomedicine accessibility and used by the locals in illness (Subedi, 2011).

Harper (2014) illustrated biomedicine and traditional healer's realm in Palpa district, and power and politics about the illness and healings. In public, he found spiritual causes of illness as; *lago, masan, chakra*, ghost, soul loss (*sato janu*), witch (boksi), sorcery (boksa), *chhauda* curse, *hansa, pichas*, sacred arrow (*baan*), *risani, baayu, kul-pitra/ kul deuta, nag* (snake god) and local god and goddess, etc. He also described the local name of diseases *moch* (miscarriages) (p.55), *aithan* (p.58) *bigaar* (pp. 53-69) and *khapate* for tuberculosis. The public also used Shamanic-spirit practices of *laamaas*, priests, astrologers, herbalists and healers from Terai in ill-health and misfortune. However, bio-medicine or pharmaceuticalization is growing in the district. He argues "bio-medical form of knowledge was introduced into the confusing array of diagnostic and treatment possibilities (Harper, 2014, p.69).

Bury (2001) has examined the illness narrative analysis which is done in humanities, social science and medicine. He further writes, the "patient of personal narratives can also be seen to stem from changes in morbidity patterns, the expansion of information about disease and illness" (p. 263). In his article, he has described forms of narrative (1) Contingent narratives; (2) Moral Narratives; (3) Core Narratives and further described as:

'Contingent narratives' which address belief about the origins of disease, the proximate cause of an illness episode, and the immediate effects of illness on everyday life; 'Moral narratives' that provides an account of (and help to constitute) changes between the person, the illness and social identity, and which helps to (re)establish the moral status of an individual or help maintain social distance; and 'Core narratives' that reveal connections between the lay person's experiences and deeper cultural levels of meaning attached to suffering and illness (Bury, 200, p.263).

He also illustrated subforms Heroic, tragic, ironic and comic, and regressive/progressive narratives and drawn a distinction. Further, he writes, "illness narratives are important for a better understanding of the social fabric, and the contradictions of social interaction and self-presentation, not simply a 'truer' picture of illness or the basis from improving medical practice, important through the latter may be" (Bury, 2001, p.283).

2.3.4 Faith Healing, Traditional Healings and Alternative Medicines

Barry (2005) analyzed the growth of alternative medicine and its insurgence where realms of biomedical system have been raising questions about the nature of evidence. He has noticed that alternative therapies in the western world in an exponential increase over the recent decades. In alternative medicines included Acupuncture, Osteopathy, Homeopathy and Reflexology. He argues that randomly clinical trial (RCT) which is used to search clinical evidence and legalized or politicized both in a biomedical system or alternative medicine system has errors; which could not protect consumer's health. Similarly, in the western world, there is hegemony of bio-medicine; so it demands RCT and evidence-based medicines (EBM) with alternative medicine systems. "Although any system of medicine covers a broad and varied range of practices and philosophies, contextualized accounts of practices and process in specific circumstances are notably lacking in most forms of research" (p. 2652). The "macro-analyses suggest that the response of bio-medicine at the system level, to the growing popularity of alternative medicine, can be interpreted as politically motivated. RCT evidence is being used strategically by biomedicine's medical associations, to reduce potential threat from alternative medicines, feeding into incorporationist and assimilationist policies" (p.2652). He further discussed the EMB and RCT has been conceptualized and ritualized; and rhetoric evidence formation in Bio-medicine, manipulation in clinical data in formation of evidences, and he emphasized to add ethnography in construction of evidence in clinical trials. Similarly, discussing RCT and EBM evidence tools of bio-medicine, he further concluded that, "evidence is used not only to assess the efficacy of therapies but also in political ways to influence how alternative medicine is integrated, assimilated or blocked from entry into the bio-medical system" (p.2655). The writer, further warned that the construction of evidence in alternative medicine via ethnographic research is also become politically challenge in hegemony of biomedicine (Barry, 2005).

In such a way, Bista and Bista (2005) illustrated the *Amchi* tradition of healing. They have stated *Amchi* tradition as an alternative medicine which is prevailed in the Himalayas of Nepal. They also illustrated the *Amchi* medicine production, clinical uses, development of *Amchi* tradition and mentioned that this system is existence in 21 districts of Nepal (p.94). Similarly, writers described medicinal plants and uses which are found in the Himalayas of Nepal, and how *Amchi* are compounding or making medicine for giving treatment to communities. They also expect the government support to develop the *Amchi* science as an alternative medicine in Nepal (Bista and Bista, 2005).

Similarly, Gartoulla (1998) has studied alternative medication practices in Nepal. He argues, "alternative medicine is a rather vague term used loosely to distinguish ancient and culture-bound health care practices which existed before the application of science to health matters. Some frequently used synonyms are indigenous, unorthodox, folk, fringes and unofficial healing" (p. 119). He has dissected and illustrated the faith healing which is prevailed in the Nepali culture, and argued as alternative medicine (pp. 119-135). He has also illustrated ethno-medicine and medication practice as alternative medicine in Nepal (Gartoulla, 1998).

In such a way, Kristvik (1999) described status and role of traditional healers, healing practices in Nepal besides the National health care system (Bio-medicine), and conflict between the traditional healer and trained health workers. The researcher has found in a survey more than 90 percent of TB patients who were taking treatment from Britain Nepal Medical Trust (BNMT), had visited traditional healer before coming into formal health institutions. Furthermore, the researcher found that "Nepali folk healers are indeed a mixed group. They differ in status and popularity as well as in technique" (p.70). The shaman has "local terms are many; a dhami, Jhankri, Phuknemanche or beidanga" (p.70). In Bhojpur *dhami* term is most frequently used, and "*Phuknemanche* does simpler part of the dhami's work (*jarphuk, phuphu*), but do not go into trance in nightly séances. A *baidanga* uses magical formulas (*mantras*) like Dhami, but most of his work is based on the use of medicinal herbs (p.71). Similarly, "dhamis can draw on a wide repertoire of technique, but shamanism is the main pillar of their work" (p.71). She has mentioned that dhamis were served in *bāli system*, which is rarely found today; *bāli system* is a traditional system where like dhami, craftsman and servants or occupations trades who get a remuneration of annual basis crops instead of money from the service provided to households (p.72). Dhami's do not take cash remuneration in healing or night séance (*chinta basne*) but "remuneration is given in kind like alcohol, and a warm meal to be consumed on the spot. Something may also be given for the dhami to take home such as rice or other grains" (p.73). The traditional healer is usually called at home but sometimes people take service where he was met in the street or teashop or everywhere. "Performance of healing rites, especially nightly séances, are an occasion that tends to attract neighbours and others that also come and ask for help, either right way, in connection with the work that is going on or to make another appointment" (p. 73). There are "two ways of becoming a dhami; learning directly from the gods (*Bhuiputta, aphaile sikne*) or receiving one's knowledge from another Dhami (*gurubata shikne*)" (p.74). Several Dhamis got their knowledge from the *bonjhankri* (forest god). *Bonjhankri* kidnapped

the man and kept some time in the forest and gave crucial knowledge *mantras* to become *dhami* (Kristvik, 1999, p.75).

In addition, Miller (1997) illustrated the traditional healing system, social relationships, ethnic situation and health care of contemporary *Dolkha* district. He found pilgrim for power gaining by the shaman is a mountain peak called Kalingchok (a shrine). They gather there for festival in full moon of July-August (Janai purnima). In festival *Jhankri's* (shaman's) chanting their *mantra* and beating a drum, trembling themselves, ritual worships which attract the peoples. Their internal dispute between *Jhankris* due to liquor or other cause, a competition of supremacy via magical battle each other. They offer and demand power with god/goddess (pp.1-55). He also stated choices of the goddess (process for selection priest, *mul*, *nari*), role of priest, *mul-nari*, *Guthiyar*, *naris* and *jhankris*; process of ritual sacrifices and worships. He also examined the ethnic views of *Thami* and *Newar* about the goddess festival or conducting *jatra*, ethnic relationships, conflict of interest and co-working. He also found that there is a history of *Thami's* origin in *jhankri's* singing oracles. The "treatment by a *jhankri*, with its hypnotic drumming and the physical exertion of trembling where one surrenders to the automatic movement of the body, could be means for him to release those tension for a period"(p.129). In addition, "there is another fact too: the treatment focuses the attention of others on his problem and its physical expression in his sickness. Those present provide him with active support in his difficulties by their interest and concern" (p.129). In spirit possessions, generally, *jhankri* received a gift called *guru-bheti* and foods for his services of healing as remuneration (p.130). Beside this, he examined the causes of a quarrel at *jatra* between *sano jhankri* group and higher caste group which was rooted in old tension about the land and resources of *Deolang*, where subordinate ethnic use their *jhankris* about the rise their problems. However, he also found inter-caste Master-disciple (Guru-chela) relationship in *jhankri* education, and their clients come from different caste and tribe (p. 203). He was worried about the Government of Nepal, who has pursued national integration objectives using ideals and customs of Hindu society; educated Nepalese and western superficially saying superstition (p. 203). Furthermore, he found doctors and trained health workers hate the *jhankris*, and discourage their traditional healing practices. However, he argues being some limitation about traditional healing, it connects human body and mind in treatment, culturally and socially to the illness and heal which is beneficial to cure illness combining with bio-medicine. Moreover, *jhankris* were preserving the Himalayan culture in the modern development age (Miller, 1997).

Similarly, Sagant (1996) has illustrated shamanism practice in Limbu culture and society including economy, politics and religion. In Limbus shamanism is associated with culture, ritual and Mundhum. In Limbus traditional and ritual healers are known as *Ya* (Yaba or Yuma; i.e. Male-Yaba, female-Yuma), *Phedangmas*, *Bijuwa*, *Jhankri*, *Sambas* and *Pirtung* (pp.339-370). He also analyzed the shaman's cure and the layman's interpretation of spiritual power and ill-health. The shamans are the middlemen between human and spiritual power, so they provide healing. He found, *Pirtung* using bear penis for treatment of misfortune (p.345), and saving life of Limbus (p.349). He also found shamanism rituals to prevent hailstorms, natural disasters, epidemic disease, agricultural production for good health. He also stated Phedangma, Bijuwa or Limbu shamans reciting *Mundhum* for their ritual purification and cure. But other *Jhankris* do not do so and they have a separate *mantra*. Further writes, "there is a relation between illness and a badly integrated past, which have conceptualized with the framework of their ideas on shame and honour"(p.360). He argues, "the shaman's cure is effective only if his clients are willing to admit their transgressions" (p.365). Moreover, "society accepts the shaman's authority over the social order only the extent that he is able to control the god; this is to the advantage of society.The link between function of healing and that of guaranteeing the social institutions is indissoluble; the relation between illness and civilization" (p.365). There is also "difference between 'sacrificing priest' and a 'medium' which shares points with the distinction between white shamans and black shaman or to adopt Limbu terms *phedangmas* and *bijuwas*" (p.366). Beside this, he found in shaman gathers information from ill-person as, "patient on his recent past: his dreams, diet, activities, social relations, violations of taboos, spirit contracts, etc. He seizes on everything that might fill in his picture of the patient's history his household and his settlement" (p.367). Then, shamans diagnose or indicate responsible spiritual causes, worshiping rituals, pig sacrifices for deities and sometimes, use medicinal herbs for health and wellbeing (Sagant, 1996).

Similarly, Maskarinec (2000) has found, "Brahman priests, astrologers, oracles, seers, counsellors, fortune-tellers, and most successfully shamans (local Nepali: *Jhāngari*) for empowering to postpone or alleviate human fate. *Jhāngaris* are Himalayan shamans"(p.3). "Utterly distinct from the disgracefully ineloquent muttering of the original man, both the long public recitals and the short private *mantars* of Himalaya shamans are polished, well constructed, orally preserved texts, meticulously memorized through years of training" and which "texts constitute the core of every shaman's knowledge" (p. 6). In his analysis of shaman's oral text, he found stories of the origin of humans, the origin of mustard oil, a story of witches, local politics, ethnic histories, local culture and religious influences. Those words

are used to cure illness. He also described spirit possession methods, their drums, dresses and curing methods for illness. In spite of that, he found Masta Dhami (shaman) as local priests too. He further writes "shaman texts do not just describe ideal situations; they impose their ideal, atemporal, divine performance on the accidental, time-bounded, and thoroughly human actions of the particular shaman who invokes them" (p.237). The shamans encourage the ill-person to raise his head in shamanistic rituals (Maskarinec, 2000).

On the other hand, Kleinman (1979) has illustrated traditional healers getting success in healing process through indigenous practices in Taiwan. According to him, traditional healers are particularly successful in treating the following kinds of conditions:

1. Acute, self-limited (naturally remitting) disease
2. Non-life-threatening, chronic disease in which management of the illness is a larger component of clinical management than biomedical treatment of the disease.
3. Secondary somatic manifestation (somatization) of minor psychological disorder and interpersonal problems (Kleinman, 1979, p.24; Kristvik, 1999, p.115)

In such a way, Stutley (2003) has argued as shamanic belief systems are gained in complexity over the centuries. "Many beliefs appear to have originated among the Paleolithic nomad hunter-gatherers" (p.1) era. The shamanic belief and practices are "found throughout the vast regions of Central Asia and Siberia, and to a lesser extent in Europe and other counties special North and south America" (p.1). The writer argues that shamanism has many variations according to cultural differences and religions, and shares three things commonly as:

- (1) belief in the existence of a world of spirit, mostly in animal form that is capable of acting on human beings. The shaman is required to control or cooperate with these good and bad spirits for the benefit of his community.
- (2) The inducing of trance by ecstatic singing, dancing and drumming, when the shaman's spirit leaves his or her body and enters the supernatural world.
- (3) the shaman treats some diseases, usually those of a psychosomatic nature, as well as helping the clan members to overcome their various difficulties and problems (p.2). Spirit possession is central to all forms of shamanism, and also has a central position in religious phenomenology and psychology (Stutley, 2003, p.3).

Further, the writer argues shamanism is not only 'religio-magical viewpoints' but there includes philosophy, naturalistic and medical elements; "specially, the psychiatric methods that appear more effective, although they pre-date by many centuries the discoveries of western psychiatry" (p.2). The "shamanism can be used in various ways since it is an element

of all religions, such as in the ecstatic, charismatic leaders of Buddhist, Jewish, Christian, Islamic and other cults and sects; or as an associated with specific cult practices- the world Tree, the fire-cult, soul-loss, soul-fight and so on"(p. 2). Beside this, "Shamanism represented a certain stage in the development of religion"(p. 4). It is assumed that the shaman word brought by European from Tungus but the origin of the term is still in dispute. The word in tungus *śaman*, in Pali term *Samana*, in Sanskrit *śramana* or Vedic term *śram*, in Chinese *Shamen* also considerable fact about the origin of word shaman (p. 3). The writer argued, the first shaman should be female (p.8) due to the matriarchal period. Later on, society being patriarchal, male shamans arose. The writer also described different cultural shamanism and tales (pp.6-72). Furthermore, the writer found burying rituals in the shaman's death and his/her corpse. There is a belief that the soul of shamanism immortal and shaman emits animal characters. So, there is a curiosity about the ancient were-animal cult (Stutley, 2003).

Similarly, Hitchcock and Jones (1976) illustrated faith healings, ritual healings and shamanism of Nepalese society with portraying within geographical and ethnic diversities. In the book, twenty different articles are included. "The essays suggest other, ways in which shamans can participants in medical development. They, together with mediums, priests and lamas, are specialists in the local ideology. Health workers attempting to introduce new ideas of causations" (p. xviii). This "will be more effective if they understand how local people interpret these illnesses". They indicated that, "In some instances, shamans are politically prominent and for this reason alone their cooperation is needed". So, they suggest that "Their support is valuable because of the number and extent of their contacts. Often they have a large clientele, including families from outside their immediate neighbourhood and from a wide range of castes" (p. xviii). The foreigner percept as like 'third religion' beside the Hindu and Buddhism for phenomena of shamanism practice cultures (p. xiii). They were indicating four types of spirit possession: peripheral possession, reincarnate possession, tutelary possession, and oracular possession (p.3). In Nepal, "Illness and misfortune are attributed to a variety of supernatural forces such as attacked by witches, sorcerers, forest divinities, spirits of deceased individuals and angry god or goddesses" (p.7). They mentioned the social phenomena of Nepal as; "throughout Nepal the caste system and ethnic pluralism operate to deny many individuals self-respect and prestige in the village setting"(p.8). Therefore, they argued in lower hierarchy castes spirit possession and ritual healings are high for "gain self-respect and prestige" (p.8) and similarly in gender-wise in females and poor families who have causes of inferiority in the society (pp.7-11). They also included an analysis of the

Nepalese code of 1854 (1910BS) about the shaman, witchcraft and sorcery to guide contemporary society (Hitchcock and Jones, 1996).

Similarly, Desjarlais (1992) has illustrated an analysis of soul loss and shamanic healing among the Yolmo ethnic groups of Helambu Nepal. In writers has described step by step analysis of social history, cultural norm and values, the influence of Buddhist, social life, local perception of illness and shamanic performance and healings. He has illustrated sensory experiences of the body and aesthetic perceptions, interpretation of illness by locals and shamanic interpretation, recent influence of bio-medicines in illness interpretation, social relationship, songs of sorrow and other phenomena. He has interpreted pain, emotions and soul loss among the Yolmo from an aesthetic perspective. He also illustrated cross-cultural analysis of illness and healings, bodily experiences of pain, illness and healing of individuals from medical anthropology discipline. He has mentioned shamanic séance thoroughly and illness interpretation from the ill-persons and their relatives. He found perceptions of 'outer illness' can cure by shaman and inner organ destruction could not; and so need to go in hospital (bio-medicine) for cure (p. 233). Similarly, he also found patients returning from bio-medicine to the shaman, who lost the soul. Furthermore, the researcher had portrayed ethnography of shamanism in the Yolmo ethnic group of Nepal (Desjarlais, 1992).

Furthermore, Harper (2014) found, in the local language shaman is called as *laamaa* and does spirit-possession for healing and misfortune. He further mentioned, "the first choice of treatment is Nepal's estimated 440,000 traditional healers. Healers are well-respected individuals who are recognized as community health leaders. Their method of treatment is based on a belief that illnesses arise when gods are displeased or when devils are at work" (Sattaur 1997, p.34; 2014, p. 43). He described diverse ethnic shamans and types of shaman; automatic shaman (bhuifutta *laamaa*) and *laamaa* from learning (p.22). The *laamaas* who learn from teachers (guru) were various sources; some were learned from Tibetan lama, some from India and someone from a local guru. He has illustrated several cases, that were treated by the traditional healers; patient satisfaction. The multiple physical disorder and nerve diseases (*nasako rog*) complained by the local patients visited Shaman He also found Bahun priest, medicinal herb seller, religious healer also providing alternative medical care in the district (Harper, 2014).

2.3.5 Medical Pluralism

Adams (2004) has stated about medical pluralism in Tibet of China. In Tibet and China, there is "cultural diversity in a robust medical pluralism in china" (p.287). He discussed ethno-medicine

of Tibet, Traditional medicine of china, barefoot doctors of china, religious and ritual specialist and western-style medicines as medical pluralism, cultural pluralism in health institutions from health ethics and equity perspective in public health care (Adams, 2004, pp. 283-305).

Similarly, Singer, Davison and Gerdes (1988) found medical pluralism setting in Haiti. they illustrated the traditional healer of Haiti as, *houngans*, *mambaos*, *malfete*, *dokte fey* (herbal healer) and *fanm saj* (midwives), and their healing practices and knowledge, folk and ritual practice for health. Furthermore, there had "practical implications for pluralistic health care setting" (p.381). They also found, "while a positive reassessment of so-called traditional medical systems and their respective practitioner has characterized the international primary health care movement in recent years", specially, for the indigenous health practitioners, healers (p.381). However, there had a practice of folk and ritual healing, spiritual healings, and traditional healings and use of therapeutic plants as medical pluralism (Singer, Davison and Gerdes, 1988, pp. 370-385).

Furthermore, Broom and Tovey (2007) examined the therapeutic pluralism in Cancer patients in the UK setting, and professional boundary disputes and inter-professional dynamics. Further, they stated in the UK, complementary and alternative (CAM) "therapeutics including (but no limit to) reiki, reflexology, aromatherapy, therapeutic massage, spiritual healing, acupuncture and hypnotherapy" (p.551). Further, they argued, "the integration of CAM should not be conceptualized as a mere challenge to bio-medicine or, as potentially contributing to this rather linear process of deprofessional." and further expressed as:

"Biomedical clinicians working in this context, who perceive CAM as an inevitable (but not necessarily appropriate) part of cancer care, are finding a way to enlist (or shape) CAMs to complement their professional role and the strength of their organization. Others, such as the clinicians in the hospital interviewed, here may view CAM as a threat to their professional process and biomedical ideological view, resulting in the deployment of particular discursive and regulatory strategies to delimit the integration, and expansions of CAM services (Broom and Tovey, 2007, p.567).

Similarly, Kristvik (1999) found medical pluralism in the Bhojpur district of Nepal. There was existence of *Dhami* as a shaman, *Baidanga* as herbal specialist and ritual healing, *Vaidyas* of *Ayurvedic* system healers in the district. The government has introduced bio-medicine as district hospital and health posts in the district for public health care. British Nepal Medical Trust (BNMT) also provided health care facilities to the tuberculosis and leprosy patients. In spite of that, the researcher found "conflict between *Dhamis* (shaman) and health post

assistants, rooted in local culture and community, have to powerful economic interests in a wider, international context. The multinational pharmaceutical companies are one example of these" (p.133). Beside this, Doctors were felt humiliating if patient went to visit traditional healers (p.133). So, health workers always blaming as superstition and unscientific for traditional health care. But, most of the peoples were consulted with traditional healers, medicinal herb specialists and *vaidyas* of *ayurved* in illness. However, popularity of bio-medicine was increasing, but misuse is also increasing, which is harmful (Kristvik, 1999).

In such a way, Maskarinec (2000) has found medical pluralism setting in Jajarkot and Rukum districts. Further, he writes:

My surprise intensified when I saw that both traditions exist outside the mainstream of the Hindu religion and social system, which I had expected to dominate local society. Both Forms and intercessors must compete not only with each other for clients, but also Brahman priest, travelling mendicants, and Jaisi astrologers of popular Hinduism, and further compete with the recently introduced, governmental-sponsored practitioners of western-style allopathic medicine. Nevertheless, throughout Jajarkot and adjacent areas, we find flourishing two distinct types of practitioners of spirit intercession, dhami whom I will identify as oracles or mediums and Jhangaris who are shamans in the most precise meaning of that term (p.72).

In such a way, Harper (2014) illustrated medical pluralism of Palpa district of Nepal. The government public health care system; district hospital, health posts and other health programs and United Mission Hospital, NGOs and INGOs hospital and health institutes, medicine shops and private doctors' clinic, private medical college and teaching hospital, private nursing home were providing bio-medical services. He also found traditional or faith healers such as; laamaa, priests, astrologers, herbal medicine sellers, tharu healers from the terai, religious healers and spiritual goods sellers, etc. Further, he described spiritual healers also from the different ethnic groups such as Bahun laamaa, Chhetri laamaa, Magar laamaa, gaine laama, bote laamaa and so on (Harper, 2014).

Furthermore, Budhathoki (2011) has pointed out medical pluralism in Malaria Endemic Villages in the Central Hill Region of Nepal. He found self-medication, medicines sold in a tea shop, shaman, using locally available herbs and shrubs for healing. He further writes:

The people of the rural areas have three choices: home remedy, traditional ritual healing and biomedical treatment (use of allopathic drugs), which can be used alone or in combination in a single episode of fever according to the conditions of the patients and

perceived cause of illness. Local people often switch from one treatment modality to another when the first treatment fails to cure illness. (Budhathoki, 2011, p.134)

In such a way, Subedi (2003) has described Medical pluralism in the Nepalese socio-cultural setting. He found a wide range of health care providers in Nepal including "medical doctors (specialized in allopathic medicine), health assistants, nurses, dispensing chemist and pharmacists, acupuncture therapist, Tibetan medical practitioner, ayurvedic practitioners, Unani medical practitioners, folk healers, tantric healers, spiritual healers, *dhami-jhankris* (Shaman), herbal doctors, traditional birth attendants, and other practitioners" (p.140). There, "non-formal or even illegal medical traditions are available as numerous alternative therapies" (p.140). He further argues that state-funded health care service was also pluralistic in character because there were varieties of services as like Army, police and civil servant hospitals for their families, medical colleges, TU Teaching hospitals, Mission hospitals, Private hospitals, health post and sub-health posts, government hospitals; where there was no uniformity in health care services. Similarly, he also found household-based self-medication, local indigenous medical traditions, Ayurvedic, Homeopathic and Unani traditions, Allopathic medical traditions in medical pluralism in Nepal (Subedi, 2003, pp.128-158)

2.3.6 Health and Ethnicity

In Nepal, generally, caste and ethnicity are considered as the same or overlapping. However, these terminologies give different contexts and meaning somewhere it may be interrelated or overlapped. Gurung (2005) defined caste and ethnicity as, "Caste as a social group within the Hindu caste system, and ethnic or nationality as a social group with its own mother tongue, native area and religious tradition. In other words, caste groups are vertically stratified by ritual status while ethnic groups are horizontally distributed in space" (Gurung, 2005, p.1).

In such a way, Ember, Ember and Peregrine (2015) illustrated ethnicity, race, ethnocentrism and inequality. They further stated, "In many multiethnic societies, ethnicity and diversity are things to be proud of and celebrated" (p.337). They explained, "Ethnicity usually involves a group of people emphasizing common origins and language, shared history, and selected cultural differences such as a difference in religion" (p.335). They also pointed out, "ethnicity is part of the system of stratification" (p.337). Furthermore, "a caste is a ranked group in which membership is determined at birth, and marriage is restricted to members of one's own caste. ...Members of low caste still cannot marry someone in a higher caste, so the caste system is perpetuated" (p.330). Similarly, they explained that, "we have seen that people tend to be ethnocentric, to view their culture as better than other culture" (p.334) which push to

construct social stratification in ethnic groups and cause inequality (Ember, Ember & Peregrine, 2015).

Sometimes, "Ethnicity understood as being synonymous with the physical features alone, of any group, is close to racial conception" (Gautam, 2013, p.41). However, "Race denotes physical features of individuals and therefore it is phenotypical in nature. People with similar physical characteristics come into the same race. Whereas, ethnicity is collective, we-feeling of individuals in a group formed on any bases like caste, class, region, religion and so on". (Gautam, 2013, p.3)

On the other hand, Gabe, Bury and Elston (2004) expressed, "concept of ethnicity and race not being clearly distinguished and dynamic and contextual nature of ethnicity being ignored" (p.14). Further, they stated, "diversity in the patterning of ethnic inequalities in health, the dominant set of explanations has been straightforwardly based on the premise of genetic and cultural difference between two ethnic groups" (p.15). They have illustrated western social facts of ethnic inequality in health as:

In fact that even at a descriptive level ethnic inequalities in health are complex aggravates this situation. Differences in health across ethnic groups, in terms of both morbidity and mortality, have been repeatedly documented in both the USA (Rogers, 1992) and the UK (Marmot et al, 1984, Nazroo, 2001). When looking at these data, the initial picture is one of uniform disadvantage for ethnic minority groups, with higher mortality (death) and morbidity (illness) rates (Gabe, Bury and Elston, 2004, pp.14-15).

Furthermore, they also stated, "there are, in fact, several alternative explanations for ethnic inequalities in health. The most frequently considered is the possibility that they are a consequence of socio-economic differences between ethnic groups" (pp.15-16). They also have discussed the occupational class for socio-economic position of ethnicity and mentioned as:

"Occupational class is commonly taken as an indicator of socio-economic position but within in and occupation class, ethnic minority people more likely to be found in lower or less prestigious occupational grades, to have poor security to endure more stressful working conditions and to be more likely to work unsocial hours (Gabe, Bury and Elston, 2004, p.16).

Moreover, they have argued, "indicators of socio-economic position suggest that socio-economic factors make a large contribution to ethnic inequalities in health" (p.16). They concluded, "Overall, then a more complex approach to the factors underlying ethnic differences

in health is required than simply considering them to be socio-economic, or cultural, or genetic - such factors are unlikely to operate in isolation" (Gabe, Bury and Elston, 2004, p.17).

In addition, Hannah Bradby (2009) stated ethnicity and inequality from medial sociological perspectives. He argued that ethnicity leads to socio-economic stratification due to the lower opportunities available to minor or excluded ethnic people because they are ranked in a low social hierarchy. Moreover, "more recent research has found that the negative association between lower class and reported poorer health among minority ethnic groups does indeed exist, providing an appropriate means of measuring position within the social hierarchy is used" (p.82). Ethnic inequalities in health have to have due to the differentiation of opportunities in education, job, social dignity, economic activities in society (Bradby, 2009).

Similarly, Sudhir Anand, Fabienne Peter and Amartya Sen (eds) (2004) have argued that ethnic inequalities in health occur due to the nation and political power. Traditional healing, ritual and cultural healings (ethno-medicines) are found in the ethnic people of the world. Modern medicine, politics and state are not providing them with opportunities for their development. Furthermore, the existing health inequalities in the society raised the question of ethics of public health care of the Nation and society (Anand, Peter, and Sen, 2004).

In such a way, Gellner, Pfaff-Czarneka and Whelpton (2016) also described ethnicity and the context of inequalities of Nepal. They have mentioned A.D. Smith's list of ethnic characteristics as, "-a collective name, -a common myth of descent, -a shared history, -a distinctive shared culture, - an association with a specific territory, -a sense of solidarity" (Smith, 1986 pp. 22-31 cited by Gellner, Paff-Czarnecka and Whelpton, 2016, p.14). They also added one characteristic as "-a distinctive language" (p.14) in the context of Nepal and South Asia. They have critically examined the history of ethnic inequality and movements, social realm, and Nepalese context. About ethnic movement, they have pointed out as:

Unlikely that ethnic activists are motivated solely by the pursuit of economic or political advantage either for themselves or for the group (they often view themselves as devoted to the selfless pursuit of a larger goal, to the detriment of their own, and their household's economic advantages; at the same time as Whelpton points out below, they often have a crude instrumentalist view of their opponents' motivations). And yet, the competition of different elites, which sometimes takes ethnic forms, does usually have political and/or economic consequences (Gellner, Paff-Czarnecka and Whelpton, 2016, p.7).

However, Gellner, Paff-Czarnecka and Whelpton, (2016) do not talk about the ethnic health inequalities but they have described the social realm, the foundation of Nepalese society and

context of discrimination which can portray accessibility of ethnic peoples who are away from the mainstream of Nepal (Gellner, Paff-Czarnecka and Whelpton, 2016). Similarly, Dipankar Gupta (eds) (1991) illustrated the caste and ethnic system, and social stratification of India; which is likely to have influence in Nepal. They have portrayed the caste system, ethnicity, stratification, power and inequality of south Asia. There is also illustrated how hierarchy and differences of ethnicity causing inequality (Gupta, 1991).

In such a way, Pratyush Wanta, Kumar Yatru and Bhaskar Gautam (eds) (2058 BS) presented diverse problems of ethnicity of Nepal which were published in different newspapers. Where, problem of education, health, opportunities of excluded ethnic people of Nepal are raised. Further, there is presented issues religion, socio-culture, history and social inequalities including ethnic inequalities of health. The issues of safe motherhood (pp.150-152), girl trafficking (p.153) of ethnic people of Nepal are also included (Wanta, Yatru and Gautam, 2058 BS).

Similarly, Keshab Khanal (2062 BS) has reported a scarcity of safe drinking water for Chepangs (an ethnic group of Nepal). They were drinking stagnant water of pond. He informed that in the Chepang village of Chitwan district could not able to get drinking water for their good health; so, villagers compel to drink stagnant water in the pond. This could cause many infectious diseases, but there was a lack of awareness. In addition, there was some problem in Majhi ethnic group of Chitwan; but, the central government had not given priority. Reporter argues that such health problems due to being an ethnic group who are not in the mainstream of Nepal (Khanal, 2062 BS, pp. 81-83).

2.4 Overview of Health Care Service of the Country

The history of health care services in Nepal is not clear. However, Dixit (2005) claims a long history from *Ramayana* period and describes story of *Sanjeebini buti* from Himalaya by Hanuman to Ram in battle with Rawan. Similarly, "Long back, in the Atharva-Veda, mentioned has been made of the *Kirata* virgins digging up medicinal herbs from the high lands.... Kalidasa has mentioned that the Himalayas abounds in medicinal plants and herbs (Gartoulla, 1998, p.70). "The history of health development in Nepal can be divided into the ancient (1st century to 879 AD), medieval (879-1768 AD) and the modern (from 1769 AD onwards) periods, Christian missionaries introduced western medicines in Nepal during the medieval period" (Teijingen, Simkhada and Wasti, 2015, p.4). However, we cannot find a clear history. The earlier western writers Kirkpatrick (1811) and Hamilton (1819) also

described limited health problems and the health care system in contemporary Nepal. Similarly, Oldfield (1880) also described health care practices of Jung Bahadur Rana period. Vansittart (1906), Hagen (2070BS) Adams (1998), Kristvik (1999), Harper (2014) and others also mentioned Nepalese health care. Similarly, the Government of Nepal publishes an annual report where it portrays national health care goals and achievements. Sometimes, critical news is published in different newspapers in current health care systems. Here, relevant previous literatures are reviewed regarding health care services of Nepal.

2.4.1 Overviews in Health Care Services

About the health care services of Nepal, Toni Hagen writes, in 1950, there were hardly 50 Medical doctors in Nepal; and most of them working in the kingdom and main cities of Nepal. In rural areas, there was a lack of health workers and medical services. So, in his trekking of geological, geographical and development studies; he did distribution some medicines for needy villagers. Therefore, villagers were thought that all white men would be doctors and have medicine. In that time, peoples lost their lives due to simple infectious diseases like Cholera, Diphtheria, Tetanus, Malaria and so on. Peoples were facing so many epidemics of various communicable diseases. In that period, Nepalese average life span was 26 years old and infant mortality rate (IMR) 200 per thousand. Time has changed, and he found in 1997, there were 75 Hospitals in different parts of the country. Every city has private Nursing homes, approximately 4000 health posts were in rural areas. Almost all the children were covered from the vaccination of DPT, Polio, Measles and Tetanus. Life span was increased to 57 and the infant mortality rate (IMMR) was reduced to 86 per thousand. Similarly, the number of doctors increased more than 2500 in 1998; and more than 42000 health workers were served all over the country, and at least 6 medical colleges were in the country. Furthermore, in every village, there were serving Women Health volunteers (*Mahila Swayam Sewak*) all over the country (Hagen, 2070BS, p.6-7).

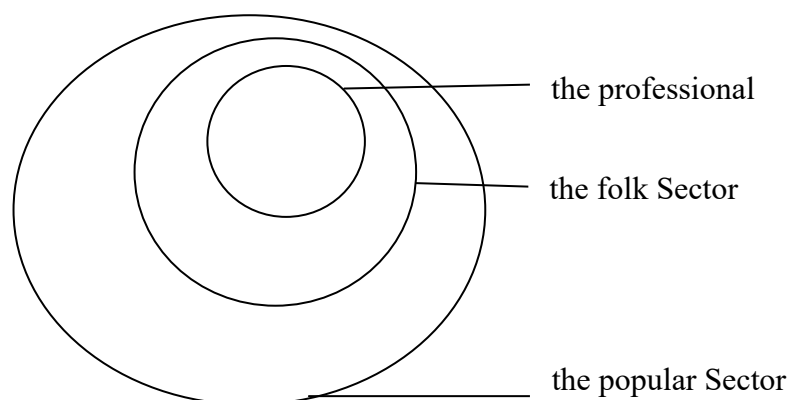
Vansittart (1906) has described health care facilities and practices in contemporary Nepal. He has pointed out astrologers or fortune-tellers who gave their service in health and well-being and further wrote, "In Nepal, astrologers form a large class of the learned community. Some of them are priests, but in general the professions are distinct". Furthermore, astrologers also serve into a determination of day to war and doing new things and he wrote, "In Nepal, the time for everything, from taking a dose of physic to the declaration of war is determined by the astrologers". Similarly, he also stated *Ayurvedic* health care service which was expended in contemporary Nepal. Further, he writes, "Baids, or medical men, are very numerous. All

families of any pretension have at least one permanently attached to their service" (Vansittart, 1991, p.53).

Adams (1998) illustrated health professionals, doctor involvement in mass movement with a white coat to throw the *panchayat* regime because there was dissatisfaction of corruption, nepotism, family-centric, *afno manchhe*, favoritism, flattery, source force (*bhansun*) among the health professionals. They wanted systematic public health care, transparent and good governance; but after the 1990's revolution established democracy could not eradicate irregularities seen as in past. About health care system, she described as "Bio-medical health care in Nepal is delivered by four types of institutions: multilateral and bilateral aid agencies; NGOs and missionary hospitals and clinics; private sector medical professionals and government" (p. 204). Further, "The Ministry of Health rural health system in pre-1990 Nepal was designated to have a health post in every *ilaka* (nine *ilaka* make up a district and there are 75 districts).There were to be 814 such health posts in rural areas" (p. 204). In these health posts; the Health assistant was in-charge, CMA and ANM were trained staff. "The health post was designed to offer minor clinical interventions and door-to-door health education, gathering of statistics, guidance for fertility control, etc." (p. 204). Although, "in the late 1980s plans were made to set up health sub-posts staffed by paramedicals in every village" (p. 204) which was established post-revolution (p. 205). There were supposed to be district-level hospital in all "districts of Nepal but in 1990 had only 61 operating" (p. 204). The "zonal hospitals received referrals from the district hospitals and in turn referred patients to the central hospital of Kathmandu (Bir and Teaching Hospital)" (p 204). The "district health officer was typically in-charge of supplies and staffs for the entire district" (p. 204). He also found a conflict between medical professionals and the government still remained after revolutions. Private sectors and NGOs are increased in bio-medical care (Adams, 1998).

Kristvik (1999) found one 15 bed district hospital, village health-posts from the government based in bio-medicine in the Bhojpur district of Nepal. In the district hospital, there were three posts of doctors "but quite often there is not even one doctor in the post" and junior health workers or nurses were compelled to "run the hospital" (p.79). In such a way, in health posts, trained health workers or health assistants often be absent, and the health posts were run by the peons. The peon was not a trained person, but he/she dispenses medicines, provides injections and prescribes in health posts and households. She also observed patients visited him/her house for medication. Medication from the government health institutions was supposed to be free, but there was always a scarcity of medicines. So, patients were

compelled to buy from private medical shops. There was an economic benefit in the relationship between health workers and the shop. In addition, most of the medical shops were owned by the governmental personnel (pp.78-83). The governmental health professional, doctors were employed central level, and most of them were from a high caste, elite class or central area. Therefore, "trained according to a 'development ideology' dispensing 'superstitions' and rural life, this category of staff often has a condescending attitude to villagers. Their health problems tend to be blamed on 'ignorance of dirty habits'(p.80). Moreover, for health workers, "career-wise a hill health post is regarded as a dead-end, the prestigious positions are in hospitals in the towns" (p.80). So, health workers from lowland do not agree to serve in the districts. Similarly, "a doctor with ambitions tends to feel that his training is wasted as a small district hospital. The popular posts are at the big training hospitals with opportunities for practice in advanced procedures and surgery facilities, far away from a village", (p.79). In such a way, the researcher stated BNMT (British Nepal Medical Trust – an INGO) which was contributing to Tuberculosis and Leprosy. In spite of this, the researcher mentioned, in "1978 the number of traditional healers in Nepal was estimated to be between 400000 to 800000". Beside this, the researcher examined the Kleinman's health care model in a cross-cultural setting (three sectors) of public health care. In (1) professional sector includes the formally institutionalized health care provider, (2) folk sectors includes non-professional and non-bureaucratic health care providers and (3) popular sector includes household and their neighbours. According, Kleinman's model, these three sectors intersect each other somewhere (p.85). But the researcher has found overlapping three sectors in the public health care system in a local setting as follows:



Source: Kristvik, Ellen (1999) in "Drums and Syringes"

Gartoulla (1998) described chronological development of Nepalese health care service and prevailing rules, regulations and acts regarding health care services. According to him, the

western medical system or allopathic system was introduced in Nepal in mid 18th century which was introduced by the Christian missionaries (p.41) during Janga Bahadur Rana period; because he had great faith in it (p.42). The Prithivi Bir hospital was established in 1889, Ayurvedic Ausadhalaya (dispensary) in 1917, and the School of Ayurvedic Medicine established in 1928. In 1933 Department of Health Services (DHS) was established; bio-medicine administration spread institutionally in Nepal (p. 43). After the revolution of 1951 (2007 BS) "more health institutions such as hospital, health centers, health posts, missionary units began coming up" (p.43). Indian Co-operation Mission provides training to the doctors in India and World Health Organization's program started to implemented through DHS in 1952. In 1955 mission hospital established. Further, Bir hospital became more efficient (p.44). He also illustrated Nepal's five years plan first to seventh plans regarding health care services. He described Nepal Malaria Eradication Organization (1958), Tuberculosis Control Programme (1965), Nepal Family planning and Maternal child health (1968), Expanded Immunization Program (1978), Leprosy Control Programme (1978), Safe Motherhood Program (1997) for their contribution and role of national health care services. Similarly, he also stated changes in health care services after WHO's Alma Ata Declaration of primary health care in 1978. Similarly, he has provided an organization chart of the Ministry of Health 1992 (p.54) and Department of Health Services (p.55). Furthermore, he has illustrated prevailed law, acts, rules and regulations regarding health care services, development of medical education. He also evaluated mismanagements in health care. He further writes, "Medicines are expensive, trained people are reluctant to go to remote areas, and moral corruption prevents proper distribution of benefits to all" (p.32). Beside this, he argues socio-cultural values of ancient health care as, "What ancient civilizations did, might not be significant from a modern standpoint but probably these were various ways of helping the sick and their families" (Gartoulla, 1998, p.43).

Dahal and Bhandari (2011) studied patient and caretaker satisfaction in curative health at the governmental hospital 'Western Regional Hospital Pokhara' Nepal. They found that people were coming to take medical service there strongly expecting cheap cost of service and availability of medicine. They also found more than half of the respondents had good satisfaction in the service of the hospital; more than half of respondents were there before visiting the private hospital. Respondents were poorly satisfied with poor hospital sanitation, poor place of examination, long waiting time for doctors and services of staff. Furthermore, 79% of respondents told that doctors gave less than 5 minutes to the patients each. Similarly, one-fourth of respondents could not get a chance to express their problem clearly with the

doctor and 22% of respondents could not get properly counselling from the doctors. In spite of that, the majority of participants told that they went to traditional healers and private medicals in illnesses (Dahal and Bhandari, 2011, pp.205-216).

Teijlingen, Simkhada and Wasti, (2015) illustrated health care service development of Nepal. They argue that "until the early 1950s, most health care was provided by family members and indigenous practitioner of several kinds, including herbalists, and spiritualists and these were used interchangeably and varying combinations depending upon availability and their situation" (Marasini, 2003 cited by Teijlingen, Simkhada and Wasti, 2015,p. 4). They stated curative health was in focus during 1960s, and preventive and promotional health intervention included in the third Development Plan (1965-70). In the fourth plan (1970-75) prioritized preventive health intervention with human resource development for health. Nepal was also involved in Alma Ata conference in 1978 and committed the slogan of 'Health for All'. So, there was developed, Nepal's First long-term health plan (1975-1990), National health policy, and 20 years long-term health plan (1997-2017). Furthermore, they also examined policy and politics in Nepal's health care services, changing status of women, sprung media, increasing migrations, urbanization and progress towards Millennium summit (2000) goals (Teijlingen, Simkhada and Wasti, 2015).

Devkota and Teijlingen (2015) studied rebel health service during the Maoist people's war of Nepal decade long (1996-2006) armed conflict. They have illustrated that the Maoist army has formed health service wings. The health workers were affiliated with political ideology. They have an estimated range of Maoist rebel health workers from 1000 to 1500; among them, 40% were female health workers (p.125). Their main responsibilities were "providing medical treatment for battlefield casualtiessmuggling wounded comrades to India for Medical treatment". They had established medical care shelters for rebels in the border area. Casualty comrades were also sent to Kathmandu for treatment in the government hospital and other institutions. The ideological sympathy keeping government doctors and health workers also helped to establish their health services (p.125). The writer also argues that the Maoist activists had a great role in advocacy for political pressure on local leaders, governmental health workers for providing service first (p.128). They also found that first rebel health workers were from those comrades, who were AHW (or CMA) or health care students in civilian life. They worked in the Chinese barefoot doctor's system (p. 126). Similarly, Maoist was conducted health worker training to produce human resources in four levels of Health works as; Ordinary (O), Medium (M), Standard (S) and Advance (A) or collectively OMSA.

The courses were near to lower-level governmental health staff. The trainers were Nepalese health workers, doctors; and some rebel health workers participated in training conducted by foreign doctors (p.126). The Maoist health workers "possess important skills such as; triaging, dressing of wounds, life-saving skills, treatment of fractures and minor improvised surgeries and amputation" (p.127). They have gained many skills "through practice, particularly on the battlefield" (p.127). The motivation of health workers to join Maoists was state's injustice for poor and rural areas, government's poor health services as well as a combination of "(a) individual related; (b) political-related; and (c) socio-cultural related factors" (p.127). Further, Maoist health workers worked in the more remote areas of Nepal, "where there was a critical need for appropriate staff to deliver minimum health service". So, "they fulfilled a gap that current government could not fulfil" (p.127). In addition to that, they found "despite high motivation to work in the health services sector, none of the Maoist health workers have been invited by the state to date to involve them and utilize their experiences" (Devkota and Teijlingen, 2015, p.129).

Harper (2014) critically examined health care provided from the Government Hospitals, Health post and sub-health posts, Mission Hospital, Pharmacy, private nursing home, Private medical colleges, NGOs and INGOs. He also illustrated informal health care from the shaman cum pharmacy, *lama* (shaman), astrologers (fortune tellers), priests, herbal sellers in footpaths found in Palpa district. He also analyzed the situation of Tuberculosis prevention program and Vitamin-A program. He found "public health officials, physicians, politicians, and the press depict certain individuals and whole groups as possessing a modern (medical) understanding of the body, health and illness and practicing hygiene as well as depending on doctors when they are sick" (p.10). However, informal/traditional healing practices are found in the district and surrounding area. He also argued that health care services in Nepal becoming pharmaceuticalization. So, *lama* (shaman), priest and others are also selling modern medicine with their traditional healing (pp.136-45). He argued that failing TB prevention and increasing MDRTB (Multidrug-Resistant Tuberculosis) in one-way political cause; and "very underpaid technicians and health workers in the government clinics supplement their meagre salaries" (p.132). Hence, they were providing low-quality services in governmental institutions. He analysed the training for shamans, and its consequences was opening bio-medical clinic for referring to patients. They were keeping stethoscope, *rudraksha* beads and selling bio-medicine (pp.56-7). So, "they reproduce the power and authority to heal" (p.57) in health care (Harper, 2014).

Dixit (2005) illustrated historical development of health care in Nepal. He further stated, "the history of medicine in Nepal may be considered to be fairly long" (p.1) and he gave an example of the story of *sajeebini* brought by *Hanuman* from the Himalaya in '*Rama and Ravana Battle*' in *Ramayan*. Further, he pointed out Lord Buddha's *vinaya* or disciplinary rules for the monks and which are guidelines on healthy living and he writes:

"Buddha laid down five essential qualities that a person attending to the sick, should:- i. be able to prescribe, ii. know what is good from what is not good for the patient, iii. attend to the sick out of love and not greed, iv. not revolt at removing excreta, saliva or vomit, v. administer religious consolation to the patient from time to time" (p.1)

Similarly, he has mentioned King Ashok established a hospital for man and animals in the ancient era and familiarity with *Ayurved* medical practices in Nepal. He also noticed that shamanism (*laamaa, jhankri, Dhami* etc), faith healers and using medicinal plants or herbs for curing and different causation of illness described by the contemporary society in Nepal and he compare these healers with 'barefoot doctors' (pp.2-4). The western medicine was introduced in 1740 (1797 BS) with King Ranjit Malla's permission and was followed by King Jayaprakash Malla in 1742. This was brought by Christian missionaries Father Greubar an Austrian capuchin monk (p.4). He also described health services of King Prithwi Narayan Shah and *Rana* regime era. With the political changes of 1950s, the development of health care expanded all over Nepal. He further stated various diseases control attempts such as caused by Viruses, Spores, Bacteria, Parasites and others in Nepal (pp.19-58). He also portrayed child and maternal health, family planning of Nepal (pp.59-85), development of medical education and health researches in Nepal (pp.86-126). Similarly, he has illustrated Nepal's five years plan from beginning to tenth; development of health services from the government sector, private sector and NGOs and INGOs. He also analysed the governments plan, policies such as first long term health plan (1975-1990), country health resources and priorities (CHRP), National health policy-1991, second long term health plan (1997-2017), National Drug policy-1995, National policy for control fo AIDS & STDs-2052BS, National Ayurvedic health policy-2052BS, Vision 20/20, the millennium development goals (MDG) and their implications. Furthermore, he described legislation, acts and rules regarding health care services (Dixit, 2005).

Naya Patrika newspaper (31 Asar 2071 BS) has reported as, ill-persons compel to walk more than two days for getting paracetamol, and reach governmental health posts in Bajura district. Therefore, the public was unable to get governmental healthcare and using local herbs and

traditional health care (Ayadi, 31 Asar, 2071 BS, p.9). Kantipur National Daily (15 Bhadau, 2071 BS) reported as an office helper (untrained personnel) was examining and treatment to a patient in the government health posts. The trained personnel were escaping away for personal benefit. Similarly, they found expired medicine, health posts closed in early time, absentee of health workers in health posts; but the government was unable to functioning smoothly (Mishra, Shrestha, Gwalai, Ghimire, Shrestha and Mali, 15 Bhaday, 2071 BS, p. 1& 14). Kantipur newspaper (03 Chaitra 2071 BS) reported quack doctors (jhole doctor) were spreading in the villages of Tarai, and patients were getting troubles through their malpractices. Moreover, there were several unregistered pharmacies and clinics run by untrained persons. There was also a problem of absentee health workers in health-post, therefore, the public were compelled to go into quacks (Dhunggana and Koirala, 03 Chaitra 2071 BS, p.13). In such a way, Kantipur (22 Saun, 2072 BS) has published news as misuse of government hospital land property. The governmental officials were not doing anything to restore the land to develop hospitals (Yadav, 22 Saun 2072 BS, p. 9).

Department of Health Services (DoHS) (2016) described a current scenario of health care provided by the government in the 'Annual Report 2071/72 (2014/2015)'. In the report, 73% children under one year fully immunized as per the National Immunization Program schedule, 97% of children aged 0-12 month were registered form growth monitoring, 765 incidences of ARI (acute respiratory infection) per 1000 children under five years (one visit) and among them 188 incidences of pneumonia per 1000 among the children of under five years, 502 incidences of diarrhoea per 1000 under five-year children (new cases) (p. xxiii) facts are mentioned. Further, 52% pregnant women got Tetanus Toxide (TT) vaccine full dose, 52% women had done delivery in health institutions. HIV cumulative reported case of a year 26,702, new case detection rate (NCDR) of leprosy is 11 per 1000000 population (p. xxiv) and National Tuberculosis Program reported 34,121 tuberculosis cases during FY 2071/72. The National Case Notification Rate (All forms) is 123 / 100,000 population (p.146) also mentioned in the report. Similarly, in the report gross national achievements of health care have been mentioned, which has portrayed our health care system.

2.4.2 Irregularities, Disorders and Ethical Violence in Health Care

In Nepalese culture and society, there we found numerous disorders, crimes and ethical violence such as; killing a person accusing Boksi (witch or sorcery). There are irregularities of economic exploitation from doctors, healers, health institutions. The news has been published frequently about premature death in doing health practice, fake doctors,

malpractice/wrong procedures, corruption in health care and so on. Here, some representative events are reviewed, in this sub-section.

Mishra (March 25, 2018) has published news about commission web-net in bio-medical health care. In this news, Doctors, Health worker were violating their ethics, involved in corruption through following commission money. They exploit patients through prescribing unnecessary investigations and medicine or food products to get bonus/commission money. They sell the patients from the government health institutions to private hospitals within the country and abroad (specially, in India) via referral tools. For this, private sectors provide money (bonus/ commission) to them. They also do unnecessary surgeries to earn extra money. Similarly, private pharmaceutical companies and private health institutes arrange a foreign tour, parties and recreations, household utensils for doctors and governmental authorities instead of prescribing their medicine and referring. The doctors and personnel were not giving time to the government hospitals or institutions. If one patient with cancer is referred to an Indian hospital, they get 15-20 thousand rupees commission. He argues that due to commission web-net, commission agent; the health care was expensive in Nepal (Mishra, March 25, 2018, pp.1-2). Similarly, Pariyar (March 25, 2018) published news about the government hospital of western regional hospital Pokhara about not providing medicines for the insured patients who did insurance as per government policy for governmental free medicines. There was also a spread-out web-net of commissions and agents. That's why; some doctors were prescribing different brand names of medicine rather than free available medicine in hospitals (Pariyar, March 25, 2018, p.3). In such a way, Sah (March 25, 2018) wrote news about the misuse of healthcare facilities which was allocated by the government for distress, hardship peoples. The powerful persons, who have access to political power, bureaucratic power, or having *afno manchhe*, are misusing such a fund. Hospital administration also accepted this issue. They gave information of one Karod Nepali Rupee distributed per year, in the name of hardship people's treatment cost (Sah, March 25, 2018, p.5). Furthermore, Yadav (March 25, 2018) has reported, a doctor had refused to give treatment for birth-giving women in the governmental Zonal hospital. He denied to treat and referred to another private hospital for the poor victim. The patient party took her to another hospital, but the Chief District Officer and high official knew this event. They called-back from the way and she was given treatment. But the higher authority did not take any action for the ethical violating doctor (Yadav, March 25, 2018, p.5)

Anmol (15 Chaitra, 2072BS), has written a news about 30 years old woman, Ramkumari Tamang (from a marginal group) who died due to vaginal bleeding at Lumbini Zonal Hospital where she was admitted for childbirth. The death was due to the health worker's negligence because they did not take care of her properly. They did not call the doctor in the ward when she was severe. But, the doctors and authorities did not take any responsibility for such negligence. So, there is risk in MCH for mothers and children. (Anmol, 15 Chaitra, 2072BS, p.5). Similarly, Dahal (5 Bhadra, 2072 BS) stated, in government hospitals, most of the instruments, which are frequently used, were often damaged. Therefore, the public were facing a problem. It was due to health personnel and authority's negligence, institutional corruption, negligence in responsibility, violence of ethics. In most cases, the machines were damaged by hospital personnel themselves for referring patients to private sectors to get commission/bonus (Dahal, 5 Bhadra 2072BS).

Gorkhapatra (26 Saun, 2072 BS) has reported a disorder of health care services in Damak of Jhapa district. Health care was profit-oriented rather than giving service, due to business-oriented health institutes, doctors and health workers. So, they were neglecting humanity and proper service (Gorakhapatra, 26 Saun 2072 BS, p.8). Misra (12 Phalgun 2071 BS) stated the several gifts, money, tour, training and many more facilities were given to doctors, health workers as a bribe from private health institution, pharmaceutical companies, medicine shops and diagnostic institutes instead of a prescription or referring to them (Mishra, 12 Phalgun, 2071, p.1). Bhusan Yadav (05 Kartik 2071BS) has reported thirteen governmental doctors (one orthopedics) of Narayani sub-regional hospital and their families were gone to tour abroad altogether, in sponsorship of private pharmaceutical company with absenting health care service at a hospital (Yadav, 05 Kartik, 2071 BS, p. 1). Mohan Shahi (12 Ashoj, 2071 BS), reported that government free distributing medicine was sold from the private pharmacy in Doti district. In such a way, Deepal Dahal, (05 Jesth 2070 BS) reported governmental doctors were brokering to a patient in referring to private hospital ICU services. Further, he reports that doctors are luring or influencing the patients and patient party to admit to ICU of a private health institute. Doctors were referring patients unnecessarily because they got bribe (Dahal, 05 Jesth, 2070BS). Similarly, Rohit Rai (32 Saun, 2070 BS) reported that the senior doctors of BP Koirala Health Science Academy Dharan referred patients to private sectors expecting a bribe. Moreover, Khatiwada (24 Asar 2070 BS) reported that it was difficult to visit doctors in the government hospitals but they easily available in the private clinic or their own private institutions. From these activities patients and their families were getting harassment in government hospitals. However, governmental authorities could not correct

such types of illegal practices because they were senior or powerful (Khatiwada, 24 Asar, 2070BS). In addition, Rai and Acharya (01 Jesth 2070 BS) also reported in Kantipur; Doctors were prescribing unnecessary and hard antibiotics to patients to get bribe/commission. They were acting as an agent of pharmaceutical company in Kathmandu valley.

Kalendra Sejuwal (26 Chaitra, 2070 BS) has reported that NGOs were conducting hysterectomy health camps for uterus trade-in mid-western Nepal. The NGOs were unnecessary removing wombs from women, to get a grant from donor and government. They also did not care well in post-operation. So, many women were suffering from complications. Among them, some were losing their money and health too. The news portraying the health camps of NGOs, INGO's trading and health politics. The government could not do anything because the NGOs owners were politically powerful and access into bureaucracy of Nepal (Sejuwal, 26 Chaitra 2070BS, p.1). Furthermore, he also reported follow-up and complimentary news in the same newspaper on the following day. He mentioned that NGO's doctors were done hysterectomy without considering age; so women were getting into trouble. The NGOs' goal was only to increase the number of hysterectomy cases; only for getting a grant from the government and donors (Sejuwal, 27 Chaitra 2070BS, p.1-2). In such a way, In Gorkhapatra (21 Kartik, 2072 BS) published the news of the death of adolescence due to unsafe abortion. According to the news, she took medicine to induce abortion from a pharmacy. She had heavy bleeding which led to kidney failure and then death. Furthermore, Arjun Shah (24 Baishakh, 2070 BS) has published news of ethical violence of identification of gender in the womb of a pregnant woman. If the fetus is found female, they induced abortion to kill her. In this case, the doctors were getting extra money in India and Nepal (Shah, 24 Baishakh, 2070 BS).

Bhattarai and Thapa (2062 BS) analysed the incidences of misconduct to woman blaming Boksi (witch) shaman, politics and public health. According to the writers, the incident was beaten, fed human excreta, and roaming village with smearing black powder in her face for a 75 years old female on Ashar 2058BS of Itisarwa VDC of Mahottari (p.130). Similarly, another incident was published in Kantipur (31 Saun 2058 BS), where 10 thousand women were gathered forcefully to find out witches. *Satyanarayan* worship organized, fed offering foods (*prasad*) for all women. The Indian shaman blamed thirteen hundred females. From that prediction of a witch, villagers were divided; so, the shaman ran away. But, the village headman blamed a woman. They beat her nakedly, fed human excreta and did public disgrace (pp.130-131). Moreover, another woman was killed blaming witch in the same district in

Ashoj month of the same year. In such a way, in the same month Asoj of 2058BS another woman was beaten and public disgrace was done, then she became ill. Serially, another incidence of crime was published in a newspaper (p. 131). Considering those incidences of crime and disorders, they argued low awareness towards witch tradition, gender biases, power politics/misuse of powers from powerful persons were the main cause of non-stopping such a kind of crimes in Nepal (Bhattarai and Thapa, pp.129-135).

Pratap Bista (28 Magh, 2072BS) published news about a 64 years old Hastabahadur Magars who was killed blaming sorcery (Boksa) by his neighbour, Krishnabahadur Magar. According to the incident of crime, Krishnabahadur had visited an astrologer (fortune teller) in the kingdom for his illness of rashes in the body. The astrologer told him to a neighbouring old man (Boksa) was the cause. Then he returned to his village of Hetauda, Makawanpur, he sprayed petrol on the old man and killed him (Bista, 28 Magh 2072 BS p.1). Similarly, Upendra Lamichhane (22 Saun 2070 BS) reported in *Nagarik* newspaper, for one female was given physical and mental torture accusing Boksi in Kingdom for three years. In addition, Santosh Sinha (21 Kartik, 2070) has published a news *Nagarik* newspaper about killing women using bullets in accusing *Boksi* in *Sarlahi* district. She had previously faced so many tortures from local powerful persons.

Subedi (2001) also illustrated the crime of blaming *Boksi*, torturing them from a medical anthropological perspective-taking several examples from the news published in the newspapers. Where, one woman was stoned to death in Lamjung district, the second case was that a woman was fed with human excreta, the third case was that a woman was tortured, the fourth case was that a woman was fed with human faces (pp. 43-44). He argued that "at least the forms of punishment which saw the forcing of excrement into the suspected Bakshi's mouth is still not as bad as the sanction occasionally resorted to, that of abject murder" (p.45). Further, he stated, "the murder was either contemplated or perpetrated by the healer, although threatened by the victim or her husband, or in some cases, a village headman, as here was no one to challenge power" (Subedi, 2001, p.45).

2.5 Medical Sociology and Anthropology in Nepal

After the revolution of 1950s, Nepal got connected with foreigners and foreign scholars had started to study Nepalese culture and society, ethnicity, geography and many more disciplines. Foreigners conducted massive sociological/anthropological studies in Nepal. Nepalese scholars

also started to give their contribution. In western, medical sociology and medical anthropology have formed in 1930s and developed after the Second World War (Cockerham 2012, p.2). But in Nepal, medical Sociology/ Anthropology emerged since the 1960s. In 1967, John T. Hitchcock published an article '*A Nepalese Shamanism and the Classic Inner Asian Tradition*' in a journal from the medical Sociology/Anthropological perspective.

Previously, earlier western writers Kirkpatrick (1811) mentioned awal jaro (Malaria) and other health accounts in his field visit on 1793 AD. Similarly, Hamilton (1819) who did fieldwork on 1803-4 AD in Nepal, also mentioned the health status of contemporary Nepal. Similarly, medical doctor, Oldfield (1880) also mentioned the health status of Janga Bahadur Rana period. After 1950s, earlier works were concentrated with shamanism, ethnic shamanism, and traditional healings. Such as Hitchcock (1967), Hitchcock and Jones (1976), Hitchcock (1976), Jones (1976), Watters (1975), Maskarinec (2000), Desjarlais (1992), Sagant (1996), Miller (1997) and so on researchers contributed in shamanism, traditional healing, faith healings, spiritual dimensions and medical sociology/ anthropology.

Similarly, from foreign scholars, Adams (1998) studied health professionals in revolution and politics. She also discussed politics, power and medical professionalism and Nepalese health care from medical sociological/ anthropological perspectives (Adams 1998). Kristvik, (1999) studied public health care in rural including local healing systems, bio-medicine practices, health perceptions and attitudes of Bhojpur district from the medical anthropological perspectives (Kristvik, 1999). Harper (2014) contributed public health care service, tuberculosis prevention, Vitamin-A programme and informal healing practices, power and politics in health of Palpa district of Nepal from medical anthropological/ sociological studies (Harper, 2014).

From the Nepalese scholar side, Devkota (1984) published an article, 'Illness Interpretation and Modes of Treatment in Kirtipur', in the journal named *Contributions to the Nepalese Studies*. He examined the medical care system of Kirtipur from medical pluralism perspective in medical sociology and anthropology. Subedi (1989) published an article 'Modern Health Services and Health Care Behavior: A Survey in Kathmandu Nepal' in the *Journal of Health and Social Behavior*. In 1992 another article 'Primary Health Care and Medical Pluralism Exemplified in Nepal: A Proposal for Maximizing Health Care Benefit' in the journal *Sociological Focus* which were in the medical sociology/anthropology perspectives (Chand and Uprety, 2013, p.6).

Gartoulla (1998) contributed to medical sociology and anthropology through study and illustrated on the history of Nepalese health care, infrastructures, illness and medication,

ethno-medicine, Ayurved, faith healing and other alternative medicines, and development of bio-medicine in Nepal (Gartoulla, 1998). Furthermore, He also published a '*Textbook of Medical Sociology and Medical Anthropology*' in 2008 for academic students (Gartoulla, 2008). Similarly, Subedi, (2001) published a book 'Medical Anthropology of Nepal', where Nepalese health care, ill-health behaviour, healing practices were illustrated. In addition, Subedi (2003), Subedi (2011) and so on are also contributing to medical sociology /anthropology. Kapil Babu Dahal (2007) published an article, 'Health Embedded in Social Context: Internally Displaced War Widows in Nepal' in the *Journal of the Finnish Anthropological Society*. Later on, he has also contributed several articles in medical sociology/anthropology. In such a way, Devkota, and Teijlingen (2009) published an article 'Politician in Apron: Case Study of Rebel Health Services in Nepal' in *Asia-Pacific Journal of Public Health*. In such a way, in (2010) 'Understanding Effects of Armed Conflict on Health Outcomes: The Case of Nepal' in journal *Conflict and Health* and in (2012) 'Why did They Join? Exploring the Motivations of Rebel Health Workers in Nepal' in *Journal of Conflictology* also published (Chand and Upreti 2013). Sinjali (2071 BS) also published a chapter article 'Magar Sannskritima Swasthya Sambandhi Paramparagat Abhyas' in his book (pp. 210-226) from a medical sociological perspective. Furthermore, Chand and Upreti (2013) have prepared an article 'Medical Anthropological/Sociological Studies in Nepal: 'A Bibliography (version 1)' which can give more information about works about medical sociology and anthropology of Nepal.

CHAPTER THREE

CONCEPTUAL FRAMWORK AND METHODOLOGY

This chapter deals with theoretical and conceptual framework, research approach, design and methods used to address the research objectives and research questions. Research methodology is a way to systematically solve the research problem (Kothari and Garg, 2015 p.7). Here, I have mentioned scientific process and methods employed in this study. In this chapter, regarding research approach, research design, sample design, types of data and data collection strategy, selection of site, research method, data collection tools and instruments, reliability and validity test have been discussed for the research works.

3.1 Philosophical Worldviews

In research, the philosophical assumptions consist of a basic set of beliefs or assumptions that guide inquiries (Cresswell & Clark, 2011, p.39). Though philosophical ideas remain largely hidden in research, they still influence the practice of research and need to be identified. The term worldview is defined as "a basic set of beliefs that guides action" (Guba, 1990, p.17). "Synonymously with worldview would be paradigm" (Cresswell & Clark, 2011, p.39) and the "idea made famous by Thomas Kuhn (1970)" (Neuman, 2014, p.96). Worldviews are a general orientation about the world and the nature of research that a researcher holds. These worldviews are shaped by the discipline area of the student, the beliefs of advisers and faculty in a student's area, and past research experiences. The types of beliefs held by individual researchers will often lead to embracing a qualitative, quantitative, or mixed-methods approach in their research. Generally "we do not need a deep discussion over the philosophical assumption to conduct research; however, we make choices implicitly among them when doing a study" (Neuman, 2014, p.93). Four different worldviews are discussed: post-positivism, constructivism, advocacy/participatory, and pragmatism as follows:

Post-positivism	Constructivism	Advocacy/Participatory	Pragmatism
–Determination	–Understanding	– Political	–Consequences of actions
–Reductionism	–Multiple participant meanings	– Empowerment issue-oriented	–Problem-centered
–Empirical observation and measurement	–Social and historical construction	– Collaborative	– Pluralistic
–Theory verification	–Theory generation	–Change-oriented	–Real-world practice-oriented

Sources: (CRESWELL, 2009, p. 6)

The study has been based on constructivism and pragmatic worldview or paradigm. In general, different worldviews or paradigms give rise to contradictory ideas, contested argument and different feature of research. Such kinds of contradictions, tensions, and oppositions reflect different ways of knowing about and valuing the social world. In this stance, there is emphasized to use multiple world view (Creswell and Clark, 2011, p.45). Here, to explore the social and historical construction of ill-health and well being's perceptions, indigenous medication practices; and to know the understanding or meaning of the phenomena related to ill-health perception and medication practice in the socio-cultural background of the Magars the constructivism worldviews was used. Therefore, the description of the research is qualitative followed by quantitative data. Similarly, through pragmatic world view, the researcher also wanted to be problem-centered, dig out pluralistic ideas in health care among the Magars and find out real-world practice orientation of indigenous Magars; and used both qualitative and quantitative tools to gather in-depth knowledge on the subject matter.

3.1.1 Metaphysics of Research from the Sociological Perspective

According to (Proctor, 1998), individuals rarely take time to do systematic inquiry in everyday life, but exploring basic personal beliefs could assist in understanding wider philosophical issues, notably ...the interrelationship between *ontological* (what is the nature of reality?), *epistemological* (what Can be known?), *axiology* (what is the role of value?) and *methodological* (how can a researcher discover what she or he believes can be known?) levels of inquiry. 'Regarding the interrelationship between ontology, epistemology and methodology of this research is explained as below:

Ontology (*Nature of reality*) of this research: Ontology is "an area of philosophy that deals with the nature of being, or what exists; the area of philosophy that asks what really is and what the fundamental categories of the reality" (Neuman, 2014, p.94). Here, ontology refers to know the nature of reality of society, particularly indigenous Magars and their perception towards ill-health and social behaviour of medication practices for healing, well-being and health. Society is the web of the relationship of individuals. It is well accepted that the Magars are indigenous peoples of Nepal and they have their own culture and language, indigenous knowledge, skills and technology, custom and living way (GoN-NFDIN, 2063 BS). These socio-cultural realities are responsible for the social and historical construction of

perceptions towards ill-health and functioning medication practices for better life and well-being. There is socio-cultural understanding or meaning about the health phenomena in the Magar society which is changing rapidly. The haphazard development and other social intervention's realities are responsible to change the indigenous perception of ill-health, well-being and medication practices. In this situation, sociologically it is necessary to know the indigenous people's perception towards ill-health and medication practices in their own socio-cultural background, to know their nature of real problems in a diverse society and to understand each-other for nation-building process through intensive research from the sociological perspectives.

Epistemology (*Theory of Knowledge*) of this research: Epistemology refers to the nature of the relationship between the knower and what can be known. Specifically, epistemology is concerned with possibilities, nature, sources and limitations of knowledge in the field of study. Furthermore, it is "an area of philosophy concerned with the creation of knowledge; focuses on how we know what we know or what are the most valid ways to reach the truth" (Neuman, 2014, p.95). Here, the history of the Magars and their socio-cultural situation, indigenous knowledge are still mysterious. Nepal is a culturally, linguistically, regionally and ethnic/caste-wise diverse country. That's why there could be a difference in perception or concept on ill-health and medication practices, and understanding level of modern health care services. This difference could be added challenges to effective health care services, humanitarian services and equity of the different ethnic groups. Not getting effective and accessible health services is increasing poverty and inequality in society. And socio-cultural factors influence the perception of ill-health and medication practices in local settings.

Axiology (*role of values*) of this research: Axiology seeks to understand the nature of values and value judgments, and of the kinds of things that are valuable. The term "value" originally meant the worth of something. Values play a large role in interpreting results, the researcher adopting both objective and subjective points of view. Axiology is closely related to two other realms of philosophy: ethics and aesthetics. Ethics investigates the concepts of "right" and "good" in individual and social conduct. Aesthetics studies the concepts of "beauty" and "harmony." Furthermore, axiology is understood as "the role values play in the research" (Cresswell & Clark, 2011, p.41). Here, axiology refers to know the socio-cultural values in idea-generating on the perception of ill-health and medication practices among the indigenous peoples Magars. The ethical concepts of right and good, and aesthetic concepts of beauty and

harmony in socio-cultural background of the Magars played role to construct their perceptions on ill-health and functioning the medication practices.

Regarding these facts, this research finds out the knowledge on concept or perceptions of ill-health and medication practice among the indigenous Magars which supports to develop a better understanding about the Magars, their indigenous knowledge and their perspectives toward on health from the sociological perspective in the Nepalese context.

3.2 Theoretical Framework and Conceptual Framework

3.2.1 Theoretical Framework

The "theories are "nets" that allow us to catch what we call the world in order to understand and explain it, and we endeavour to make the net's mesh ever finer and finer" (Cockerham, 2013, p.1) and "social theory is a system of interconnected ideas. It condenses and organizes knowledge about the social world" (Neuman, 2014, p.57). In addition, "over time theories may be discarded as social conditions change or better theories emerge; consequently, theoretical work is continually ongoing and evolving" (Cockerham, 2013, p.2). Therefore, to catch the answers to the research questions, sometimes there may be needed more than one (multiple) theories to construct the nets.

Furthermore, many sociologists believe that society is a structure and social unit/variables are functional to run society. Hence, here, the Magar society was taken as a whole component (structure) and the socio-cultural influence in the perception of ill health and medication practices in day-to-day living was explored here as a part (social units) of the Magar society. Therefore, the main model of this research is based on a structural and functional model/theoretical perspective.

Under structural and functional model/ theory, this research work has adopted Talcott Parsons and Robert K. Merton's ideas. Talcott Parsons has provided "ideas on the four functional imperatives of all action system—adaptation, goal attainment, integration and latency (AGIL)" (Ritzer, 2000, p.269) and, further he mentioned, "his structural-functional approaches to four action system – the social system, cultural system, personality system and behaviour organism (Ritzer, 2000 p.269) and social changes occurred as per biological shaped evolution theory (Ritzer 2000, p.242) Furthermore, "Culture mediates interaction among actors and integrates the personality and the social system" (Ritzer, 2000, p.239). Moreover, Parson has written the concept of the sick role to explain the functional

structuralism model and in this model, "social systems were linked to systems of personality and culture to form a basis for social order" (Cockerham, 2012, p.170). In functionalist theory, "sickness is dysfunctional because it also threatens to interfere with stability of the social system. The medical profession functions to offset the dysfunctional aspect of sickness by curing, controlling, or preventing disease and by establishing technology" (Cockerham, 2012, p.169). In this research perception of ill-health is a perception of social dysfunction or dysfunction of structures (social units) and medication practices function to offset the dysfunctional aspect to run the society among the Magars. Similarly, Structural-Functional theory of Robert K. Merton, introduced the concept of manifest and latent function. "In simple terms two terms, manifest functions are those that are intended, whereas latent functions are unintended" (Ritzer, 2000, p.246). "This idea is related to another concept of Merton – *unanticipated consequences*. Every action has both intended and unintended consequences" (p.47). In society, "although everyone is aware of the intended consequences, all the consequences of social factors are not always manifest or intended result so directly or indirectly unintended result is coming in society" (p.47). Hence, "Sociological analysis is required to uncover the unintended consequences; indeed, to some, this is the very essence of sociology" (Ritzer, 2000, p.247) to explore the concept of ill-health and medication practices among the indigenous people Magars.

In such a way, symbolic interactionists do not deny the existence of Social structures but argue that people construct them and reproduce them (Charmaz and Belgrave, 2013, p.13). The symbolic interactionism perspective in studies on socio-cultural context, there have "two parts—Symbol and interaction—produce meaningful interaction. That interaction involves giving social objects symbolic value. Social objects can be any things—physical objects, animals, history, language, ideas, emotions— as well as self and other people" (Adam and Sydie, 2011, p.503) Further, Symbols are abstract meaning attached to things, people, and behaviour so that they can have a different meaning for different individuals. The important point is that individuals consciously and creatively evaluate, make a decision, and act (p.504). And interaction involves the self engaged in communication with self: selecting, checking, suspending, regrouping, and transforming meaning in terms of the social context and the individual intention and interest (Blummer, 1969:5; Adam and Sydie, 2011, p.504). "In social interaction, people learn the meanings and the symbols that allow them to exercise their distinctively human capacity for thought" (Ritzer, 2000, p.356) in their socio-cultural context. Similarly, "Mead (1934) theorized that language is pivotal for the development of self and the conduct of social life. For mead, self and mind develop simultaneously and depend on

learning the language and symbolic meanings of one's community" (Charmaz and Belgrave, 2013, p.13). In addition to that medical sociologists are studies on individual's social identity (credible or discreditable identity), stigma potential, social locations, cultural meanings and grouped affiliations in symbolic interaction. The symbolic interactionist perspective leads to studying self-construction, interaction, actions, and meanings in the empirical world (Charmaz and Belgrave, 2013, pp.14-15). In this study, the issue of health, illness and medication is based on Magars's social structure and their socio-cultural context. Therefore, their language, symbolic meaning of existing culture and social performance; and individual or social interaction within the society are valuable to construct their concept on ill-health and medication practices. That's why the symbolic interactional perspective is also used as an assistant model to explore the findings.

In addition, in this research work, social construction or constructivism model also adopt to explore the findings of the research because this research is focused on socio-cultural meaning or perception towards ill-health, well-being and socio-cultural behaviours in medication for healing and well-being among the Magars. Social construction represents a major theme in sociology, and this social construction perspective or theory has played a main role after Berger and Luckman (1967) works (Olafsdottir, 2013, p.41). "From a constructionist perspective, a social construct is an idea that appears to refer to some obvious, inevitable, or naturally given phenomenon, when in fact the phenomenon has been (in full or part) created by a particular society at a particular time" (Barker, 2010, p.147). In addition to that, Kristin K Barker suggested, "Social constructionist scholars emphasize the relationship between ideas about illness and the expression, perception, understanding, and response to illness at an individual, institutional, and societal level. Historical and cross-cultural comparisons are effective ways to illustrate social constructionists claims" (Barker, 2010, p. 148). And in medical sociology or sociology of health and illness, social construction theory or model focused on, "(1) the cultural meanings of illness; (2) The distinction between the normal and the abnormal; (3) How illness responses are embedded in the community/ Culture; and (4) How medical knowledge itself is impacted by the social factors" (Olafsdottir, 2013, p.42). Therefore, here, the social and historical construction of perceptions towards ill-health and well beings, health-seeking behaviours through the constructive model is illustrated to answer the research questions and understand the phenomena about the health, illness and medication practice behaviours among Magars of the study area.

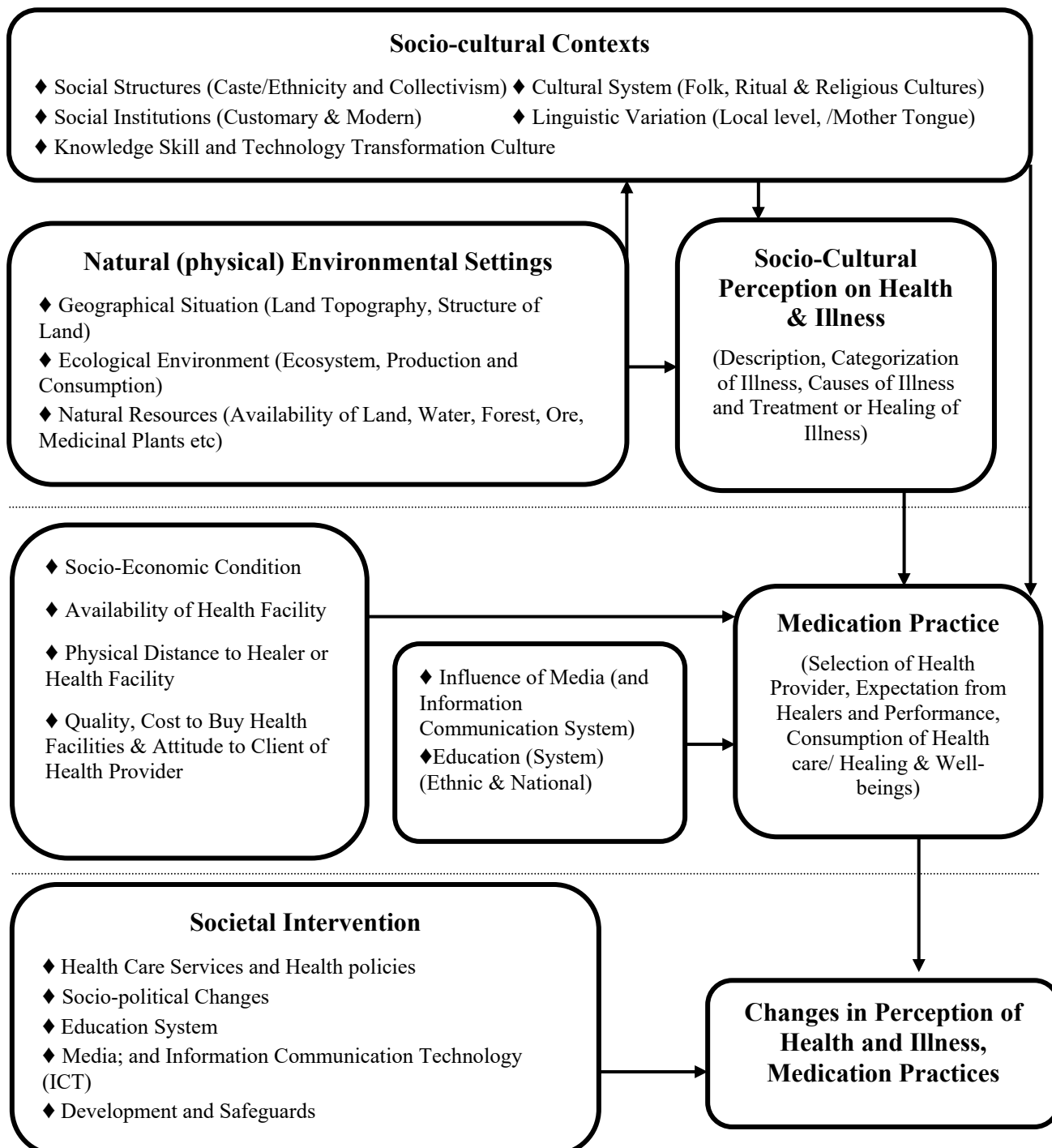
In such a way, in this research work, gender and health care theories or models also used to describe the perception of illness and medication practices among the male and females of Magar respondents. Charlotte Perkins "Gilman's maintained that men and women are born equal and it was cultural conditions that divide them" (Adams and Sydie, 2011, p. 275) and further Gilman argued that "gender is a social construction, and economic dependencies, in particular, is the critical factor maintaining modern gender inequality" (Adams and Sydie, 2011, p.275). Therefore, "Gender is a significant dimension of social stratification that affects men and women as both provider and recipient of health care" (Anspach, 2010, p. 229). In medicine from biological perspectives, manifested gender-specific medicine in society considering "the science of the differences in the normal physiology of men and women and the ways that they experience disease" (Annandale, 2013, p.165). And, those who seek to understand the relationship between gender and health today is facing challenge "how to make sense of this theoretically without jettisoning the conviction that, the changes outlined apart, all is not necessarily equal in the world as far as gender is concerned" (Annandale, 2013, p. 160).

Similarly, local health care (traditional, modern or alternative) have a role in the construction of idea in ill-health and medications. So the Kleinman's cross-cultural and local health care model, where he argued that, "to understand patients and healers we must study them in particular cultural environments and they make cross-cultural comparisons to seek generalizations about these fundamental human experiences (Kleinman, 1980, p.8) and further, in Kleinman model of health care in local setting, health care is described as a "local cultural composed of three overlapping parts: the popular, professional, and folk sectors" (Kleinman, 1980, p.59-50), which are also seen among the Magar's habitat land.

Collectively, this research work is based on structural-functionalism theoretical perspectives adopted by Talcott parsons and Robert k Merton's ideas. However, to describe perception of ill-health and medication practices of Magars in day to day living, the symbolic interactional perspective, Kleinman's model of health care in local setting, constructionist perspective of knowledge, Gender and health care theory or models were taken to assist in analysing the finding of the objectives of the research.

3.2.2 Conceptual Framework

The conceptual framework is based on structure and functionalism perspectives for this study which is presented as follows:

Figure 3.1: Conceptual Framework

Approach: Structural-functional (Talcott Parsons and RK Merton's ideas), Symbolic Interaction model, Kleinman's model of health care in local settings, constructionist perspective of knowledge, Gender and health care model

To understand the concept of ill-health and medication practice in a socio-cultural context among the indigenous peoples Magars; several factors are playing a role in society. First, the socio-cultural perceptions (concepts) towards health and illness lead to choose the medication (healing system) from available medical (healing) services. The socio-cultural concepts on

health, illness and healings being a member of society; helps to the description of ill-health and well-being, categorization of illness, causation of illness and healings or treatment of illness. The perceptions on health, illness, well-being and healings of individuals are affected by a wide range of socio-cultural and environmental factors. The socio-cultural factors such as social structures (caste/ethnicity, class, hierarchy, social stratification and collectivism), social institutions (modern and traditional) cultural systems (folk culture, ritual culture, religious culture, ethnic cultures/ customary laws and practices), linguistic variation (local language/mother tongue), knowledge skill and technology transformation culture, ethnic teaching and learning practices in the community of local setting influences to construct a perception of ill-health. Similarly, natural environments like geographical situation (topography, land structure for production and livelihood), available natural resources (forest, medicinal plants, ore, land, etc), environment (social and natural) and interaction with local people has a great role in the construction of local culture. Besides that, the natural and social environment influence on the perception of ill-health and well beings in a local setting. The publicity of bio-medicine culture is a major influencing factor to change traditional or local socio-cultural perceptions. The Magars are indigenous peoples, so they have their own education system, beliefs and worldview, indigenous knowledge. Therefore the construction of concepts towards ill-health, well being is distinct from others.

The constructed perception or concept from socio-cultural context towards ill-health, health and well-being leads to medication practices i.e. choice of health care system, selection of health provider, expectation from the healer and medication performance for healing and well-being. However, the medication practices are influenced by the socio-economic situation of the individual or family, availability of health services in local areas, physical distances to healer or health facilities, mass media and information-communication technology, family education system, ethnic culture as well as national mainstream education. Similarly, it is also influenced by the quality of healer or health care, cost to buy health facilities and behaviours of healers towards clients from service providers. The change in health in medication practice (health-seeking behaviour) is due to changes in the concept towards health & illness and health care facilities. Furthermore, the societal intervention like health care services in the local level, health policies of the state and international agencies, changes in socio-politics in the national and international, adopted education system from the state, broadcasting and publication of health matters in media, information and communication technology, modern development and adopted safeguards for local level which leads to changes in perception of ill-health and medication practices in the local setting.

3.3 Research Approach

Research approaches are plans and the procedures for research that span the steps from broad assumptions to detailed methods of data collection, analysis, and interpretation (Cresswell, 2014, p.3). This study is based on structural-functional perspectives. To describe the research work from the structural-functional perspective, two types of approaches: inductive and deductive approaches were used in this research. The deductive approach is applied for quantitative data interpretation and the inductive approach is applied in the interpretation of qualitative data in the study.

3.3 Selection of Research Site and Informants

In this research, the Magars of surroundings Tamkikot hill of Syangja district from western Nepal was taken where nine VDCs i.e. Chandibhanjyang, Lasargha, Birgha Pindikhol, Shreekrishna Gandaki (Currently; Kaligandaki Rural municipality); Nibuwakharka, Pelakot, Jagatradevi, Malungga (Currently; in Galyang Municipality) of Syangja district was included. The perception of health, illness and medication practices behaviours are influenced through the community's socio-cultural background (Kleinman, 1981; Park 2005; Helman, 2007; Cockerham, 2012). In the surrounding the Tamkikot hill of the Syangja district, the Magars speak their own Magar language and practice their own traditional culture. Hence, the area was selected. The study location lies in the mid-hill of Nepal. In the north of the study area, there lie Parbat and Gulmi districts; Gulmi district in the west, and Palpa district in the south. The Magar language is not spoken in Parbat and Gulmi districts and western Palpa, but it is spoken in the mid and eastern parts of Palpa and Syangja districts. Geographically, the borderline of Gulmi and Palpa districts is separated by the Kali Gandaki River. The Magars of the study area have slightly a difference in culture and language from Rukum, Rolpa and Dolpa districts. Similarly, the Magars of Arghakhanchi, Gulmi, Baglung, Parbat, Myagdi districts and western Palpa have been facing the problem of losing their ancestral mother tongue. However, in the study area, the Magars speak their ancestral language; and in close contact with the Magar language non-speakers' zone. In the study area, they are protecting indigenous knowledge, skills on their ancestral language till this date. However, due to the modernization, roads and infrastructure development, development of media and education, political and social changes, the knowledge, attitude and practices of health, illness and medication are changing. That's why the study location was chosen for this study where such type of studies had not been carried out before.

3.4 Research Design

"The research design is the plan, structure, and strategy of investigation conceived so as to obtain answers to research question and to control variance. The plan is the overall scheme of program of the research" (Kerlinger, 2010, p.300). This research was based on a non-experimental cross-sectional and qualitative cum quantitative (mixed) research design. In this study exploratory, descriptive and co-relational research design has been adopted for quantitative data and phenomenological research design was used for qualitative data interpretation.

In descriptive and exploratory research design, data collection involved in order answering the questions about the opinion on particular issues and it is also called the survey design. In survey research, it is used "a written questionnaire or formal interview to gather information on the backgrounds, behaviours, beliefs or attitudes of a large number of people" (Neuman, 2014, p.49) and used frequently in descriptive research design (Neuman, 2014, p.49). The finding of the research was concentrated to analyse the answers to the 'what' questions in a descriptive way and 'how' questions in an exploratory way. In addition, the collected data determine whether and to what degree a relationship exists between two or more variables involves in co-relational research design. The degree of relationship had been expressed as correlation coefficient.

Furthermore, the "qualitative data are voluminous, diverse and understand". And "sometime come from in the form of numbers; more often, the data written or spoken words, actions, sounds, symbols physical objects, or visual images (e.g. maps, photographs, videos)" (Neuman, 2014, p.204). "Phenomenological forms of qualitative research study the real world; focus a human communication, and try to delve into its meaning so that the human experience can be appreciated more richly and fully" (Baker, 1999, p.242). Furthermore, "phenomenological study describes the meaning for several individuals of their lived experiences of a concept or a phenomenon" (Cresswell, 2007, p.57). And here, from the collected qualitative data, there is described their experience or empirical knowledge and perceptions of a social phenomenon regarding ill-health and medication behaviours of Magars through the phenomenological interpretation.

3.5 Research Method

The study had followed quantitative cum qualitative research method which also called mixed research method. In the mixed method, "investigator collects and analyzes data,

integrate findings, and draws inferences using both qualitative and quantitative approaches and methods in a single study" (Tashakkori & Creswell, 2007b, p.4; Creswell & Clark, 2011, p.4). In research, conducting the multi-method study that draws on the strengths of both the quantitative and qualitative approaches (Neuman, 2014, p.17). Mixed methods research is an approach to inquiry that combines or associates both qualitative and quantitative forms. It involves philosophical assumptions that the use of qualitative and quantitative approaches and the mixing of both approaches in a study give more in-depth understanding of research issues. Thus, it is more than simply collecting and analyzing both kinds of data: it also involves the use of both approaches in tandem so that the overall strength of a study is greater than either qualitative or quantitative research (Creswell, 2009, p.4). In quantitative research; where the researcher systematically asks same questions to large number of peoples; and he/she records their answers (Neuman, 2014, p.49). Quantitative research involves the use of methodological techniques that represent the human experience in alpha-numerical categories and qualitative research provides detailed description and analysis of the quality, or the substance, of the human experience. This research was conducted in concurrent mixed method. **Concurrent mixed methods** procedures are those in which the researcher converges or merges quantitative and qualitative data in order to provide a comprehensive analysis of the research problem. In this design, the investigator collects both forms of data at the same time and then integrates the information in the interpretation of the overall results (Creswell, 2009, pp 14-15).

3.6 Sample Design

"A sample design is a definite plan for obtaining a sample from a given population. Population or Universe means all the items of the inquiry or investigation made are completely enumerated in inquiry" (Upagade & Shende, 2012, p.36). Sample design "refers to the technique of the procedure the researcher would adopt in selecting items for the sample. Sample design may as well lay down the number of items to be included in the same i.e., the size of the sample" (Kothari and Garg, 2015, p.52).

In Nepal, there are 125 ethnicity/caste groups (CBS 2011). Among them, 59 are registered as indigenous peoples of Nepal (GoN-NFDIN, 2063 BS). For this study, indigenous peoples Magars were selected. The Magars are found all over Nepal and all districts; among them, Syangja district was taken for the study sample. In Syangja district, there were three electoral regions for constitutional assembly and parliament; and two municipalities and sixty VDCs (village development committee). Among them, electoral region number third was selected

purposively because there is a dense settlement of the Magars. In this electoral region, nine VDCs and the Magars of those VDCs were selected for the research work.

3.6.1 Targeted Population

This research is focused on the Magars of Nepal in the subject of ill-health and medication behaviours. Therefore, the universe of this research belongs to the entire Magar ethnic population of Nepal. Similarly, the study population is the Magar population of the study area i.e. 18,818 (female 10,919 and male 8,255) and 4243 households.

The sampling frame is informants of 636 households out of 4243 Magar households of nine VDCs of Syangja district for quantitative data (see section 3.6.2). Similarly, 55 key informants, participants of nine focus group discussions are sampling frame lists of the qualitative data.

3.6.2 Sampling Procedure, Sample Size and Distribution

For the study, it was not possible to carry out a census of the Magars to find out ill-health and medication concepts in their socio-cultural situation of the whole population due to time and budget. Therefore, the respondents were selected using the probability sampling method. The total population of the Magars in Syangja was 62074 and the average household size was 4.2, therefore, the total household of Magars became 14,780. In the study area, according to VDC-wise calculation (see table no 4.2.2.3), there were 4,243 households of Magars (CBS, March 2014).

To calculate the sample size for quantitative data, we have the following formula if there is a known population of the study area:

$$n = \frac{\frac{t^2 \times p(1-p)}{e^2}}{1 + \frac{t^2 \times p(1-p)}{e^2 N}}$$

Where,

n = required sample size

t = confidence level

p = estimated prevalence of the risk factors within the target population in the study area

e = margin of error

N= Finite Population of the study area

Step 1 calculation of basic sample size:

Here, we have;

n = required sample size

t = confidence level at 95% (standard value of 1.96)

p = estimated prevalence of the risk factors within the target population in the study area at 50% (standard value of 0.5 (WHO))

e = margin of error at 3.65% (standard value of 0.0365)

N = 4243 (Magar households in the study area)

Therefore,

$$n = \frac{\frac{t^2 \times p(1-p)}{e^2}}{1 + \frac{t^2 \times p(1-p)}{e^2 N}}$$

or

$$n = \frac{\frac{(1.96)^2 \times 0.5(1-0.5)}{(0.0365)^2}}{1 + \frac{(1.96)^2 \times 0.5(1-0.5)}{(0.0365)^2 \times 4243}}$$

or

$$n = \frac{\frac{0.9604}{0.00133225}}{1 + \frac{0.9604}{5.65273675}}$$

or

$$n = \frac{\frac{0.9604}{0.00133225}}{\frac{5.65273675 + 0.9604}{5.65273675}}$$

or

$$n = \frac{\frac{0.9604}{0.00133225}}{\frac{6.61313675}{5.65273675}}$$

or

$$n = \frac{720.8857}{1.1699}$$

or n= 616.19 \approx 616

Step 2: Adjust for expected non-response to get final sample size:

It is estimated that there is chances of 3.3% non-response or missing data/questionnaires, so 3.3% is added in basic sample size:

Here, 3.3% of 616 = 20.33 \approx 20

So, 616 + 20 = **636**

∴ Final adjusted Sample size (n) = 636

Therefore, finally, 636 household respondents were included from the nine VDCs for quantitative data of the study area. And, this sample size became 14.99% (where 14.99% \approx 15%) in the total (4243) Magar households of the study area. Furthermore, 15% of the total household (4243) is equivalent to $636.45 \approx 636$. Therefore, 636 households were selected for the study through random sampling in every VDCs. Each VDCs of the study area was given an equal weight of 15% of respondents to gather the information from all VDCs of the study area. The VDC-wise sampling distribution is shown in table 3.1:

Table 3.1: Sampling Distribution According to VDC

SN	Name of VDC	Total HH	Total Population	Average HH size	Total Magar Population	Magar HH	Sample HH 15%
1	Jagatradevi	2050	8700	4.24	3457	815	122
2	Malungga	678	3,230	4.76	851	179	27
3	Pelakot	1220	5748	4.71	1712	363	55
4	Pidikhola	1119	4956	4.43	1082	244	37
5	Nibuwakharka	790	3875	4.91	1864	380	57
6	Shreekrishna Gandaki	1993	8815	4.42	3190	722	108
7	Birgha	1180	5117	4.34	1847	426	64
8	Alamdevi	908	3844	4.23	2456	581	87
9	Chandibhanjyang	981	3942	4.42	2359	534	80
Total		10919	48227	–	18,818	4243	636

Source: Field work record of VDC & CBS 2011

The table 3.1 shows sampling distribution according to VDC wise of the study area. The Jagatradevi and ShreeKrishna-Gandaki VDCs have higher households of Magars, therefore respondents are higher number comparing other VDC and Malungga VDC has least populations in the study area. However, every VDC has an equal quota of 15% respondents in comparison to the study population.

3.6.3 Sample Size for Qualitative Data

Initially, an additional 15% (around 95 participants) of 636 sample size was planned to in-depth interviews of key informants for collection of qualitative data to study for the inclusion of all VDCs and dense Magar Villages of the study area. But, finally, qualitative data was collected from 55 were selectec purposively for in-depth interviews on the basis of data saturation of information in the field. However, all the VDCs were covered for in-depth interviews. In the information collection process, the same information was used to repeat from the next respondents then the researcher came to know the saturation of information and stopped data collection. Researchers generally use saturation as a guiding principle during

their qualitative data collection. Guest, Bunce and Johnson (2006) suggest, "Although the idea of saturation is helpful at the conceptual level, it provides little practical guidance for estimating sample size for robust research prior to data collection" (2006, p.59).

3.6.4 Selection of Respondents and Its Justification

Respondents were selected by using simple random sampling. The criteria were considered to select the sample respondents:- older than 21 years old, household head or having major responsibility in conducting household function for household survey. Almost adolescent characters transferred to adulthood around 21 years old age, which grown-up maturity in the respondent. Similarly, those persons who have household responsibility, they also have grown-up maturity in the sense of experience, knowledge and practices regarding health matter too. Therefore, mature respondents could give better information to understand their concepts towards ill-health and medication. Hence, the discussed criteria were fixed to collect quantitative data. And senior citizens, leadership persons, respected people in the society and those people who have in-depth knowledge about the Magars and their culture were selected purposively the key informants to gather qualitative data.

3.7 Nature and Source of Data

In this research work, the nature and source of data were primary sources as well as secondary sources to find the result. The primary data were collected through questionnaires and household surveys, observation of the cultures and healing practices, in-depth interviews with the key informants, case study, focus group discussion (FGD). Similarly, the researcher participated in local socio-cultural events or occasions during the period of in the field visit. In order to check the factual information, an attempt was made to cross-check the information obtained by asking the same questions to other respondents.

Secondary data were collected through the library method; reviewing the related books, journals, articles, research reports, unpublished materials, magazines and newspapers. Secondary data was also collected from secondary resources such as VDC records, district profiles, NIFIN Profiles, Central Bureau of Statistics, Profiles of DPHO & Ministry of health, bulletins, Various literatures, journals, newspapers and reports related to Socio-culture, health and illness issues.

3.8 Research Instruments/ Data Collecting Tools

In this research, both qualitative and quantitative methods were applied to find out the result. The following tools were used to collect the data.

3.8.1 Quantitative Data Collection Tools

3.8.1.1 Household Survey

The structured interview schedule was administered to collect primary quantitative data from the respondents. This technique was used to collect data from the household survey. One respondent was selected from one household. The respondent was the head of the family or guardians who had in-depth knowledge of their socio-cultural practices. Gender participation was considered during data collection.

3.8.2 Qualitative Data Collection Tools

In this research, phenomenological and narrative approaches were adopted during the collection for qualitative data. The following data collecting tools were used for qualitative data collection

3.8.2.1 In-depth Interview with Key Informants

In-depth interview is helpful to gather qualitative information on the topics from the key informants or persons who have knowledge of the community. Semi-structured and open-ended checklist was used in qualitative data collection. In that process, probing questions were raised to find a causal relationship between socio-cultural practices of medication and perceptions about the topic. The key informants were senior citizens, local leaders, local teachers, shamans, faith healers, relatives of ill persons or recovered ill persons and the persons who were familiar with the socio-cultural practice of the Magar.

3.8.2.2 Focus Group Discussion

Focus group discussion (FGD) was conducted to collect primary data. Semi-structured and open-ended checklist was used to gather information from the focus group discussion. Six to twelve persons of the local community such as senior citizens, local leaders, healers, teachers, relatives of ill persons or recovered ill persons and those persons who have in-depth knowledge about socio-cultural practice of Magar were selected for participation in FGD. The focus group discussion was conducted in every VDCs; one FGD in each respected VDCs; and in total nine FGDs were conducted during the field visit. The information gathered from the FGDs was useful to verify Key the informants' views, experiences and realities of the society.

3.8.2.3 Observation

Observation is also an instrument/tool to collect qualitative data in the community. To understand the reality of socio-cultural practices related to health, illness and medication

practices, health-seeking behaviour observation in the study area to get valuable information is beneficial. "Basically, there are two modes of observation: we can watch people do and say things, and we can ask people about their own action and the behaviour of others" (Kerlinger, 2010, p.537). The occasional field visits were carried out on different occasions and festivals, rituals and other social events in the study area on 2014 and 2015 AD; and extensive observations were carried out from January to July 2015. During the field visit, physical settings of the study area, cultural practices, *Ghantu* and other folk dances, *Chandi Puja* and worshipping to god, feast and festivals, health care practices and many more were observed, and these were related to the issue of perception of ill-health and medication behaviours. The observation procedure to collect qualitative data was of both modes of observation: watching people what they do and say things, and asking their actions and the behaviours of others in the field. The information gathered from the observations was beneficial to verify key informants' information and find new information too.

3.9 Secondary Data Collection

In this research work, various statistical tools and methods were used to collect and gather information from the secondary data. The secondary data collections are as follows:

a. Document Review: University libraries and libraries of different organizations and book shops were visited to collect the documents or information for secondary data, and they are presented in the reference section. Similarly, I visited different governmental and non-governmental offices visited for issue-related annual reports, research reports and document collection for secondary data. The collected documents, reports, books, journals, articles which are related to this research work are reviewed thoroughly and listed in the reference section.

b. Web Search: The information related to the topics from the outside region (other parts of Nepal and the globe) was studied from the websites. Topic-related articles, journal articles, periodic records and reports, documents electronic/internet search was carried out from the websites and the list relevant web search are mentioned in the reference section.

c. Various policies of the Government and other National organizations were dealt in detail by referring to various government publications and reference books, journals, published data from time to time and relevant are mentioned in the reference section.

3.10 Process and Procedure in the Field

To conduct data collection in the field, firstly, structured questionnaires and checklist were developed. The developed questionnaire and checklist were sent to the dissertation supervisor (expert) for comment and recommendation. Based on the expert's suggestions, the questionnaire and checklist were amended. Then, a relationship with the local communities and people of the study area was developed. Similarly, to develop the relationship, the *Yaunat* festival and *Jiwai-mama* folk dance were observed at Lasargha in *phagu-purnima*, and Chandi-puja and Ghantu folk dances at Ramche and Chitung villages in *Buddha Purnima* and other usual festivals in the study area of 2014 AD.

Furthermore, the developed questionnaire and checklist were piloted (pre-tested) at Ilhunggā (a Magar village) of Jagatradevi VDC of the Syangja district on the first and second week of December 2014 AD. Altogether 10% of respondents of the total sample size were contacted requesting to contribute to testing. The questionnaires and checklists were revised. The respondents were randomly selected and panel respondents were male and females. From the pilot survey and research, the questionnaire and checklists for both quantitative and qualitative data were reviewed and amended taking suggestions of the experts.

In the second phase, the final questionnaire and checklist were employed in the field. In February 2015 AD, enumerators were selected and given training for the household survey. From the first day of March 2015, the household survey started in collecting quantitative data and ended in July 2015. Meanwhile, the relationship-building process within the community continued and started focus group discussion (FGD), in-depth interviews with the key informants, observation and case study for qualitative data until the last day of July 2015.

3.11 Variables in the Research

Variable means an image, perception or concept that can be measured – hence capable of taking on different values (Kumar, 2009, p.55). "A variable is a property that takes on different values. Putting it redundantly, a variable is something that varies. ..Variable is a symbol to which numeral or values are assigned" (Kerlinger, 2010, p.29). Variable can be subjected to measurement by crude/refined or subjective/objective units of measurement. Therefore, it is known as the key element of a research study. The related variables were identified in the study through the literature reviews and discussion with experts to address the objectives of the study.

In this research, **dependent variables** are concepts of ill-health and medication practices. **Independent variables** are perception (knowledge), attitude, socio-cultural beliefs, awareness, etc. **Background/Demographic variables** are Gender, age, marital status, education level and occupation/profession.

3.12 Reliability and Validity

3.12.1 Reliability

Pilot test of instruments: The data collecting tools, questionnaire and checklists were piloted at Ilhunggā village; a Magar village of Jagatradevi VDC of Syangja district. In the pilot test, 10% (or 64) household's sample size survey was done in the field in December 2014. The objective of the piloting was to access reliability of the questionnaires and other research instruments developed as a part of the research work. The questionnaire and other research instruments were piloted among a similar participant and the community. The reliability study was carried out by using a clarity test. The piloting of the questionnaire and other research instruments were carried out as: (1) household survey in the community, (2) Focus Group discussion with community leader, senior peoples, teachers (3) Interview with key informants (4) socio-cultural event observation (5) test-retest methods. After the pilot test of research instruments, necessary reviewing and amendments were carried out for final data collection.

Language translation-back- translation: The questionnaire and other research instruments were first developed in English and later translated in Nepali and again translated into English. In the field, during data collection period, both the Magar language and Nepali language were used for data collection. The researcher and selected enumerators were fluent in both Magar and Nepali languages. The enumerators were graduate students having fluency in both languages. They were six (2 males and 4 females) in number. This team was trained by conducting full two days orientation session. On the first day, they got orientation about the nature of the study, the pattern of questionnaires and interview schedule, rapport building skills, communication skills. On the second day, they were given an orientation on research ethics and data collection techniques by doing a more practical session. The enumerators did an exercise that how they would take the interview of the respondents, how to convince respondents to participate in research work, what types of language should be used and how to rise the probing questions to find the appropriate answers. After that, each enumerator was provided a diary, a pencil, an eraser, a sharpener, a bag and an individual consent form for the respondents, questionnaires and checklists.

The researcher monitored them regularly in their fieldwork activities to verify the quality of data. Likewise, the researcher was involved in an in-depth interview of key informants, focus group discussion, observations of socio-cultural events and collection of the case study. The data collected in the Magar language was translated into Nepali and Nepali to English. The translation was carried out by the freelancer translator.

Furthermore, for the reliability of the primary data, the research was collected through interviews, questionnaires, field surveys and observation in the researcher's active spot participation in the Magar villages. The researcher supervised regularly for factual data.

3.12.2 Validity

The logical validation was followed on the basis of common sense and theory. A measurement instrument is valid when the conclusion from the scores of that instrument is in agreement with the measurement aim of that instrument. When two different measurement instruments with the same measurement aim lead to the same conclusions in the same situations, this can be taken to be a strong indication of the validity of the research instrument.

Panel of experts: Content validity of the questionnaire and checklists were addressed by identifying items from the literature and through assessment by both experts and participants in the pilot test. The questionnaire and checklist were sent to a number of experts (supervisor and co-supervisors) for their comments, suggestions and recommendations. Based on their suggestions, the questionnaires and checklists were revised.

3.13 Data Analysis and Interpretation

The statistical analysis was completed through applied statistics and Statistical Package for Social Sciences (SPSS), a statistical software package for quantitative data. In this research work, Chi-square (Pearson), percentages, frequency and mean were used to analyze the differences of opinion among different groups of respondents, for example, Gender, Age Groups, education level, occupation/professions. Paired sample test (t-test), correlation (Spearman's rho), standard deviation, mean were also done to know the significant difference between in time duration change of total perception of ill-health and medication practices in different groups.

In addition, the open-ended responses of the respondents were analyzed using qualitative methodology. The collected information was analyzed and interpreted to synthesizing the result of the work. Furthermore, the qualitative data collected through various techniques and sources; the narrative forms were prepared individually of KIs and in group information from the observation and focus group discussion. The gathered information was put together

collectively in subject wise; and tabular form. The opinion and information from the informants were summarized thematically and analyzed in a simple form to describe and presented in descriptive form.

The result obtained from qualitative data and quantitative data was gathered together, and summarized in objectives-wise form with mixing and merging both data results. Then conclusion was carried out on the basis of summarization of the results. Similarly, data gathered from household surveys, in-depth interviews with key informants and focus group discussions were triangulated by using information gathered from observation, and with documents in order to test their validity.

3.14 Ethical Consideration During the Research

This study was conducted in the social science discipline; however, the study was related to health. Therefore, ethical approval was taken from the "Ethical board" of "Nepal Health Research Council (NHRC)" of Nepal, Ministry of Health and population on dated 26 July 2015 as Reg. no. 47 (See Annex-II). The researcher followed the following techniques as research ethics to maintain the privacy of respondents, and reliability and validity of data in study:

3.14.1 Voluntary Participation

In this study, the respondents were requested for their voluntary participation and there wasn't any coerced to them because, in basic ethical principle, any people shouldn't be coerced in taking participation, when they might object to being a "Guinea Pig" in the research.

3.14.2 Informed Consent

The researcher gave clear information about the research project and their participation. And before starting the interview with the respondents, the written consent form was filled to ensure their voluntary participation.

3.14.3 Confidentiality

Respondent's information privacy was well maintained during and after study. Participated respondents were convinced about the confidentiality of their information, so that information could support getting the real response.

3.14.4 Anonymity

When respondent remaining anonymous due to differing from confidentiality, or interviewing environment or situation, at that time use of telephone or via a remote method such as letter

by post, emails would be useful, and which gives greater ability to sustain privacy to the respondent. But, in this study, such situations did not come.

3.15 Field Experience

I have experienced many positive aspects as well as challenges during the field study period. Though the study area was my birthplace, I have not visited all the Magar villages. I had worked for about one year as a health worker in that local area 17 years ago. Last year, I just resigned from health care services to conduct my study. So most of the Magars know me as a health worker, therefore, during data collection, they shared their personal or family health problems and expect some medicines from me. Similarly, some villagers assumed me as INGO personnel and asked me for the projects of infrastructures or developments in their villages. In the field, when I told them that I was there for study purposes, they were surprised and asked me why I was there in the village instead of taking classes in the city. Furthermore, being a Magar, some villagers do not believe me as a PhD candidate. When I talked with them in the Magar language, the respondents accepted me closely and provided information easily. Sometimes, the respondents talked about their personal health problems, social problems, exploitations from powerful persons and social inequalities too. Thus, I listened to their problems without any haste. It helped me to understand the local social issues in-depth. Listening to me, one local shaman who was at the age 77 from Lihunk village of Chandibhanjyang VDC and in bed-ridden stage due to stroke and paralysis showed interest to talk with me. And, he shared his healings practices and services which he had been giving, however, was worried that nobody was interested taking his knowledge from him due to the influence of modern medicine. He also claimed that he did treatments of several serious illnesses in the community at his active age and blessed me for success in my study work. In addition, the study area was a hill area. Most of villages were connected with the non-metallic road (Kachchi and dhule Sadak) which were narrow, stiff and sloppy, dusty in the dry season, and muddy in the rainy season. The vehicles were not regular to reach the villages. So I had a compulsion of walking from one village to another, however, it was enthusiastic and delightful for me. During the field stay, the key informants, the participants of the research and villagers were helpful to share information for my research.

On 24 April 2015, I discontinued my second phase fieldwork which was started on 1st of February month and headed to Kathmandu for a workshop/seminar on 25th of April. But, there was a destructive earthquake of 7.8 magnitudes that trembled Nepal on Saturday 25 April 2015 (12 Baisakh 2072) 11:56 AM. The earthquake had the epicentre at *Barpak Gorkha*. The earthquake

added casualties and destruction in the capital city and surrounding districts. After the earthquake, many people were leaving Kathmandu and there was a shortage of vehicles for travelling out of Kathmandu. After one week, I left Kathmandu and reached my research area. Fortunately, there were no casualties and massive destruction; however, few houses were cracked, but people had a normal life. There was the preparation of *Buddha Purnima*, *Chandi Puja*, *Ghanto folk dances* celebration. I joined with local people and I collected some information too. Meanwhile, another destructive earthquake tremor of 7.3 Magnitude hit on Tuesday 12 May 2015 (29 Baisakh, 2072) at 12:50 PM making an epicentre in the border of *Dolakah* and *Sindhupalchok* districts. These two destructive earthquakes took life around nine thousands, and more than 3 million people become homeless or affected. So I postponed my field works. After one month, again I reached the study area. There, the houses which had small cracks before had bigger cracks due to the second huge shot of the earthquake. People were expecting some relief or support to construct their own destructed buildings; however, the relief programs were minimum in that area. Most relief and support programs were centered in the heavily affected area. However, the majority of data was collected within the last day of July 2015. Still, some verification of information remained unfulfilled. Rainy season started, so this verification task was postponed. When the rainy season was almost over, the constitution assembly passed the Constitution of Nepal on 20 September 2015. Then some unrest was seen in Nepal. Meanwhile, the border unrest was seen and it was converted into the blockade which last for a few months. Due to this blockade, a crisis of petroleum products occurred and other crises got added. This blockade added some troubles to go the field and verify the information, however, all verification works finished within 2015. Hence, I experienced two destructive earthquakes and one blockade in my data collection period which added troubles in my daily life too.

During the field stay, being the Magar and knowing the mother tongue, it was easy for me to get hosting in the villages. There was not any difficulty for lodging, food and guidance to search for potential informants, participants. But, there was a challenge of unnecessary information gathering. However, there were no chances to escape from listening to their issues. Furthermore, they were also showing interest to know contemporary Magar issues from me because it was the period of constructing the constitution of Nepal. But I talked less about contemporary issues because I have known that society was divided into many groups through political ideology, and their quarries were not helpful to my study.

CHAPTER FOUR

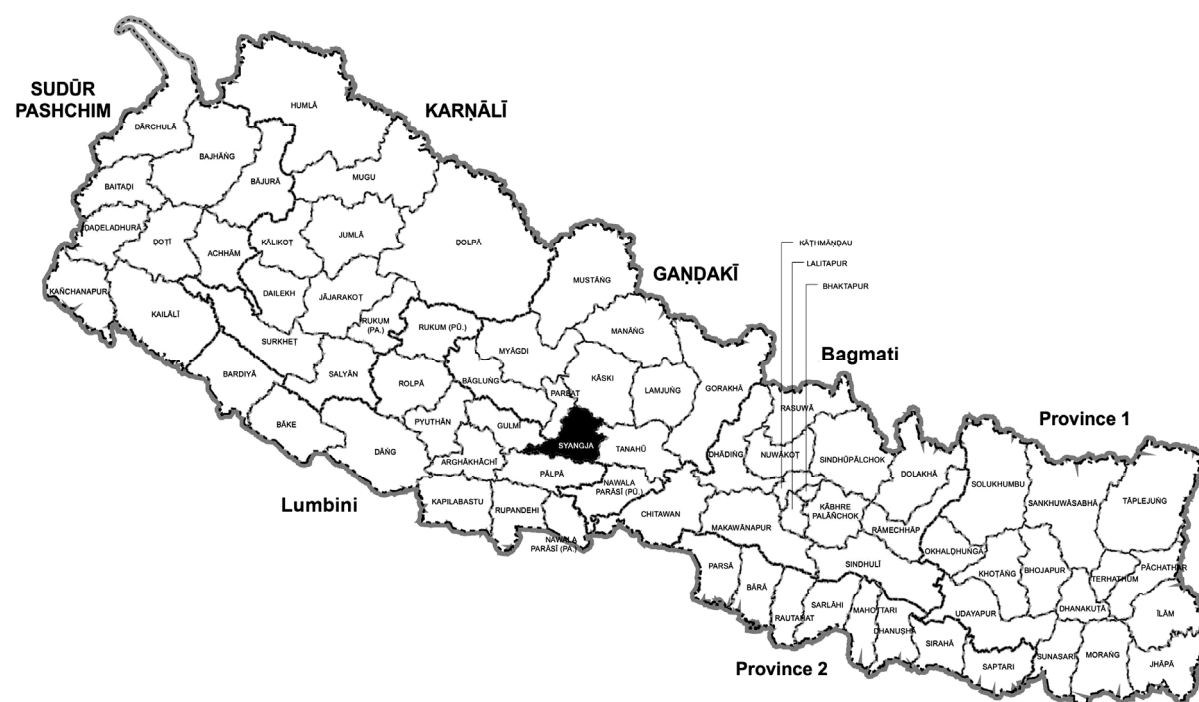
THE SETTINGS AND CHARACTERISTICS OF THE STUDY POPULATION

The chapter deals with the backgrounds of settings such as Syangja district and surrounding Tamkikot hill. In this social and physical environmental setting, the Magars (study population) are surviving and constructing their own socio-cultural perceptions towards health, illness and medication practices. In addition, the characteristics of the study population are discussed in this chapter.

4.1 Background of the Syangja District

4.1.1 Introduction

The study area surrounding Tamkikot hill located in the Syangja district of Gandaki province in the current political division of Nepal and it is erected basin of Kaligandaki river where the Magars are found with their mother tongue and cultural with their own distinct identity. Syangja district is a hilly district where geography, flora and fauna, ethnicity, culture, language and societal diversities are found which lay neither in Terai nor in the mountain (Himal). This area lays in the mid of the hilly (Pahad) region. Palpa District and Nawalparasi districts lie in the south, Gulmi and Parbat district in the west, Kaski district in the north, and Tanahun district in the east of Syangja district in the current political division.



Source: <http://dos.gov.np/?albums=maps-of-nepal> (Accessed on 30 March 2019/Edited by researchr)

4.1.2 Historical Background of District

Syangja is one of those districts of Nepal which lies in the mid-hill area and approximately central from the east-west distance as well as north to south. The district's name is derived from the place Syangja (District headquarter); nowadays it is also called Putalibazar. There are not proved facts about the naming of Syangja, however, there are some arguments that are discussed here. (1) Once the Adhikhola (āngdi) river was blocked due to flood and landslide, the river sunk that place and became distressed for all living public. In this disaster, one of the religious old men prayed the god saying "Syaiya ja". As per his wish, the river got opened and all water became clear and there was relief. Later on, a corruption of the word "Saiya ja" becomes Syangja. (2) Before unification, there were small Chaubise kingdoms in the Magarat region. Among them, one clan was "Sen" and their son (jā) and their living place became "Sen + ja". Then the word got corrupted and became Syangja. (3) In the district, there was a dense living of Singjali Magars (a clan of Magar), therefore, the place name became Syangja (Karmachari Milan Kendra, 2060 BS, p.1; DDC Syangja, 2064 BS, p.4; Sinjali and Rana 2073BS, pp.105-6). Another argument also prevailed as (4) in hunting and gathering time, there were found wild peasan (Digwā) and other wild birds, the hunters killed the wild peasants and wild birds. They ate and remembered it as Syā Jyācha (eating meat) place which was corrupted and became Syangja. Similarly, some are also connected with Hindu Sage's name in the naming of Syangja. The connection with Hindu Sage and word "Syainya Ja" is the influence of Sanskritization. Other arguments related to the Magar language, Magars and Thakuris of the districts. In Magar language 'Sing' means wood, Jyāhake means doing craft and 'Jā' means son or offspring, the whole meaning could be woodcraftsmen's son living place for *Syangja* (Sinjali and Rana, 2073BS).

The history of the *Syangja* district is not known clearly yet. In ancient history, Kirant era could be governed from ancient Nepal and in Lichhavi period *Syangja* could be Nepal kingdom and '*Magwar bisaya*' (Magwar district) because copper plate written about '*Magwar bisaya*' of 1100/1AD has been found (Witzel, 1991). After the establishment of the 'Singja' Kingdom, *Syangja* district could belong to Singja Kingdom. The falling Lichhavi dynasty and becoming weak power of Mall dynasty of Nepal Kingdom and falling power of *Singja* kingdom; in the *Magarant* area there were established so-many small kingdoms called '*Baise* and *Chaubise*'. In *Baise* and *Chaubise* period, there was found the existence of *Bhirkot* kingdom, *Satahun* kingdom, *Garaun* kingdom, *Dhor* kingdom within the district. Some parts of the *Syangja* district were ruled by the *Paiyu* kingdom of *Parbat* and *Sen Kingdom* of *Palpa* (Gartaula, 2017, pp. 92-104). In *Baise* and *Chaubise* period alteration of the boundary of the

kingdoms and wars between kingdoms were usual, after the unification process of King Prithvi Narayan Shah, *Syangja* was again included in greater Nepal. In addition to this, the *Argha*, *Khanchi*, *Gulmi* and *Parbat* Kingdom did not rule in the study area of *Syangja*, because *Gulmi*, *Arkha*, *Khanchi* and *Parbat* kingdoms were against the Magar language and banned their own kingdom in the medieval period. Magar language is spoken in the study at the present date.

4.1.3 Geographical Situation of Syangja District

Syangja district is a hilly district and lies in the mid-hilly region of Nepal. The area of the Syangja district covers 0.79% of the total area of Nepal (DDC Syangja, 2067 BS, p.2). DDC Syangja (2064 BS) stated that geographically Syangja spreads in between east meridian of 83°27" to 84°2" and north parallels of 27°50" to 28°15" and a total area of the district is 1164 sq km. The east-west length is 22.508 km to 52.355 km and the north-south width is 2.773km to 37.839 km (p.4). The geo-land of the Syangja district is high and low with sloppy and upright steep which is made of hard and soft rock. Most of the district area is structured by metamorphic stratified rock (p.5). The lowest altitude is *Keladighat* (366 meters) and the highest altitude is *Panchase* (2,512 meters) from the sea level (p.3) In the district, the land is as categorized as (a) approximate plain land is 30.35 sq.km.(2.96%); where agriculture can be done easily, (b) medium steep slope land 40.45 sq.km. (3.83%) which is useful to agriculture and forest, (c) mild zigzag steep land is 4.73sq.km. (0.45%) where cultivation can be done making field terraces, (d) high zigzag seep land is 25.51 sq.km.(2.44%) where jungle, grass and timbers can be cultivated, (e) having steep slope land is 480.75sq.km. (45.96%) which can be used to produce jungle for timber and firewood, and grass cultivation and (f) highly steep sloppy land is 463.83 sq.km. which land is useful only cultivate jungle for timber and firewood (p.4). About use of land; in the district, 27.2% of the land is covered by forest, 8.8% by animal grazing land, 19.2% land is not qualified for agriculture, agriculture is done in 43.3% of the land, and 1.5% of the land has been used for other purposes (p.5).

The climate of the district has been categorized in three categories; (1) hot climate: approximately 15% of the land has hot climate which lies on the bed of rive or stream and low land, (2) tropical (*samashitosna*) climate: approximately 70% land has a tropical climate, and (3) 15% land has cool (*shitoshna*) climate (DDC Syangja 2064, pp.9-10). There are Kaligandaki river and Andikhola river (*āngdi*), and Jyāgdikola, Pindikhola bid streams in the district. There are also more than 4 dozen small and medium streams in the rivers which are mixed into Andhikhola, Jyagdikhola, Kaligandaki and Seti Gandaki from the district.

4.1.4 Population Distribution of Syanja District

Population is the truth of society and culture, and without humans, it is impossible to the formation of human society and culture. The CBS 2011 shows Syangja district carrying the load of 1.09% of the total population of Nepal and in past 1.81%, 1.59%, and 1.37% were in CBS 1981, CBS 1991 and CBS 2001 accordingly. The population distribution according to different CBS is shown in table 4.1:

Table 4.1: Population Distribution in Different Censuses of Syangja District

Census in AD	Population			Sex Ratio	% of the National Population	Yearly Growth rate	Population density per sq km	HH	Average HH size
	Female	Male	Total						
1981	142,158	129,666	271,824	91.21	1.81	0.12	234	48,415	5.61
1991	157,357	136,369	293,526	86.66	1.59	0.77	252	55,497	5.29
2001	173,701	143,619	317,320	82.68	1.37	0.78	273	64,746	4.90
2011	163,315	125,833	289,148	77.05	1.09	- 0.93	248	68,881	4.20

Source : CBS 1981, CBS 1991, CBS 2001 & CBS 2011

The Table 4.1.4 shows that the population of Syangja district was increasing from the Census 1981 to the Census 2001. After 2001 CBS, the population of the district was found reduced and significantly seen in CBS 2011. The reason for the degrading population in the district is migration and attraction by other developed places. Furthermore, according to CBS 2011, a population of 50,476 was absent when the population was counted. Among them, 46,024 were males and 4,451 females due to various reasons that they were living in a foreign country including India.

4.1.5 Status of Ethnicity/Caste in Syangja District

Ethnicity/Caste diversity is found in the Syangja district and there are more than fifty ethnic/caste groups in the district according to CBS 2001 & 2011. The highest population of ethnicity/caste is Brahman-hill (30.881%) and secondly Magars (21.468%). The population of Magar is 62,985 (21.468%) where 26,985 are males and 35,089 females in CBS 2011 and it is 21.192% or 67,245 (30,809 males and 36,436 females) in CBS 2001. Similarly, the third position is Chhetri (11.526%), fourth Gurung (8.966%) and accordingly, the fifth population is Kami, sixth Sarki, Seventh Dholi/Damai and other ethnic groups are found. In addition, Syangja district has access to roads and easily accessible from any parts of the nation. So some Terai ethnic groups are also found according to censuses, however, the population is significantly difference according to CBS 2001 and CBS 2011. The detail of ethnic/caste population distribution in Syangja district is presented in Annex-III.

4.1.6 Religious Status in Syangja District

Syangja district is found diverse in religion however there is a majority of Hindus according to Census 2011. There are 8 types of religions found in CBS 2011 and 7 types of religions in CBS 2001 excluding unidentified or others in the district. The distribution of the religion in the Syangja district is presented in table No 4.2:

Table 4.2: Population Distribution According to Religion of Syangja District.

SN	Religion	CBS 2011				CBS 2001			
		%	Total	Male	Female	%	Total	Male	Female
1	Hindu	90.207	260,832	113,381	147,451	86.067	273,107	123,422	149,685
2	Buddha	7.440	21,514	9,367	12,147	12.468	39,563	17,976	21,587
3	Islam	0.684	1,978	932	1,046	0.578	1,835	886	949
4	Kirati	0.007	21	14	7	0.003	10	8	2
5	Christian	0.201	582	259	323	0.066	211	127	84
6	Prakriti	0.013	38	12	26	0.000	0	0	0
7	Bon	1.286	3,717	1,654	2,063	0.000	0	0	0
8	Jain	0.000	0	0	0	0.008	25	13	12
9	Bahai	0.002	6	2	4	0.003	10	2	8
10	Sikh	0.000	0	0	0	0.000	0	0	0
11	Undefined/ Others	0.159	460	212	248	0.806	2,559	1,185	1,374
	Total	100	289,148	125,833	163,315	100	317,320	143,619	173,701

Source : CBS 2011 & CBS 2001

The table 4.2 shows that the religion-wise population where Hindu is the highest position with 90.207% in CBS 2011 and 86.067% in CBS 2001. The population of Buddha religion was found decreased in CBS 2011 than CBS 2001. The *Prakritik* or animism religion also appeared in CBS 2001 where the majority of Indigenous people worship natural objects in the district.

4.1.7 Status of Languages Spoken in Syangja District

Syangja is a multilingual district according to CBS 2011 & CBS 2001. The main language is Nepali due to the National Language, and being the mother tongue of Brahmin, Chhetri and other ethnic groups. Also, it is found that there are other indigenous ethnic languages like Magar, Gurung, and Newar in the district. Most of the names of places, villages, rivers and streams of Syangja district were derived from the Magar language; however, these are going to be changed according to the present national spirit. Multi-lingual society is the heritage of

Nepal which shows a colourful garden and beauty, therefore, national heritages are found in the district.

The distribution of Language-wise population of the Syangja district is presented in table 4.3:

Table 4.3: Population Distribution According to Mother Tongue/Language

Language	CBS 2011				CBS 2001			
	%	Total	Male	Female	%	Total	Male	Female
Nepali	74.384	215,080	93,337	121,743	71.111	225,651	101,646	124,005
Magar	15.097	43,654	18,916	24,738	16.873	53,541	24,385	29,156
Gurung	7.754	22,421	9,834	12,587	9.168	29,091	13,127	15,964
Newari	1.671	4,831	2,118	2,713	1.949	6,184	2,837	3,347
Urdu	0.345	999	442	557	0.253	803	408	395
Bhujel	0.223	646	279	367	0.000	0	0	0
Bhojपुरी	0.096	279	177	102	0.034	109	89	20
Maithili	0.068	196	121	75	0.045	144	96	48
Tharu	0.066	190	143	47	0.043	137	104	33
Hindi	0.054	157	113	44	0.060	189	148	41
Rai	0.046	134	70	64	0.012	39	28	11
Kumal	0.028	81	39	42	0.000	0	0	0
Tamang	0.015	42	32	10	0.049	157	103	54
Thakali	0.012	36	17	19	0.011	35	19	16
Sign Language	0.011	33	18	15	0.003	11	5	6
Avadhi	0.011	31	22	9	0.001	3	2	1
Bote	0.009	27	15	12	0.000	0	0	0
Limbu	0.007	20	11	9	0.008	24	16	8
Bangla	0.004	13	9	4	0.001	3	1	2
Others	0.021	60	26	34	0.071	226	139	87
Not Reported	0.075	218	94	124	0.307	973	466	507
Total	100.000	289,148	125,833	163,315	100.000	317,320	143,619	173,701

Source : CBS 2011 & CBS 2001

The Table 4.3 shows the picture of languages of the Syangja district. According to CBS, the majority of the people have Nepali as their mother tongue and the Magar language is in the second position. The Magar language speaking people are found decreased (by 1.78%) in CBS 2011 as compared to 2001. It is because the Magar language and other ethnic mother tongues are not in the mainstream and received no promotion in the government education system, media, administrative sector, development sector. So the Nepalese heritages are going to die and tend to disappear slowly from the district.

4.1.8 Road, Transport and other Infrastructures

Syangja district lies in the hilly geographical region and it is difficult to construct road networks for every village or human settlement area from the viewpoint of sustainable environment-friendly development. However, village roads are being constructed everywhere from the community level. In Syangja, Siddhartha Highway passes from the mid-portion of the district. All VDCs and Municipalities are connected with roads. Syangja district has 149.7 Km pitched (black-top) road, 13.5 Km gravel road, and 616.1km un-metalled (Kachchi) road.

There are 149 trust bridges (Jhalungge pul) and 10 concrete bridges in the rivers. There is also an approximately 7 Km water-transport (waterway) into the Kaligandaki-A hydropower dam and it runs to Mirmi to Setibeni bazaar border of Parbat district, and there is no airport in the district (DDC Syangja, 2072BS, p.10).

Syangja district is rich in the production of electric power from hydropower. In the district, Kaligandaki-A Hydropower generates 144-megawatt electricity, and AndiKhola Hydropower produces 5.1 megawatt electricity. Syangja has 17 Piko Hydropower (up to 3 kilowatts) which generates 37.5 kilowatts. Similarly, there are 8 micro-hydropower (3-100 kilowatt) institutions that generate 100.3kw electricity and there is another micro-hydropower that will generate 87kw electricity power. (DDC Syangja, 2072BS, p.10 and DDC Syangja 2067 BS p.7). In the district, almost all villages have electricity; however, there were 4 VDC that were away from the hydro-electrical power ((DDC Syangja, 2072BS, p.10).

This development of infrastructure added easy access to biomedicines. The electricity helps in drinking water distribution in the villages, and power for light, ICT, media. The road-head added Ayurveda, Homeopath, Acupuncture and other health facilities in the district from the governmental and private sector too. The road and connectivity increased migration, immigration and risk of communicable illness in the districts. And haphazard development added risk of environmental degradation which is a risk for illness and degradation of indigenous culture, language and indigenous knowledge in health, healings.

4.1.9 Education and Educational Facilities in Syangja District

In Census 2011, Syangja district has a literary rate of 76.6%. Among them 86.05% males and 69.5% of females were literate. However, the district literacy rate is 97.6% (DDC Syangja, 2072, pp. 6-7). In the district, there were 588 pre-primary or child development centers. Among them, 507 are community and 81 institutional (private). There were 387 primary schools (357 community, 30 were institutional (private) schools) in the district and 73 schools were lower-secondary (57 community and 16 institutional/private). Similarly, in the district, 74 schools were secondary school (49 community and 25 institutional [private] schools). The 85 schools were higher-secondary schools where 75 were community and 10 were institutional (private). In such a way, there were 18 campuses/colleges in the district, among them, 15 were community and 3 were institutional (private). There were also 3 Ashram (Hindu religious school) and 6 Madarasa (Muslim religious school) in the district (DEO Syangja, 2069 BS, p.2). The community schools were run by government educational grants.

In addition, there were two technical colleges in the districts that produce CMA and JTA (Agriculture and Veterinary).

4.1.10 Health Facilities in Syangja District

The district has 13,847 improved health ovens that emit low smoke and helpful for a healthy environment in the household of the rural village. In rural villages, cooking energy comes from firewood which emits more smoke (DDC Syangja, 2072 BS, p.10). Drinking water supply is vital for health and sanitation. In the hilly area, drinking water is scarce in high altitude villages, however, currently; water-lifting through electricity or solar energy is launched in the districts from the GOs, NGOs and INGOs. Syangja district has 68,881 households in census 2011 and for these households report of DDC (2072BS) stated water sources as 56,927 drinking water tapes, 84 hand-pumps/tube-wells, 2,695 wells (inar/kuwa) with having roofs, 3,917 wells (Inar/Kuwa) without roofing, 4,592 water source taps (muldhara), 405 streams/rivers and 170 other sources of drinking water (DDC Syangja, 2072 BS, p.6).

In Syangja district, there is one District Hospital (of 15 beds), 3 Primary Health Care Centers, 18 Health Posts, 47 Sub-health Posts and one District Ayurvedic Center from the government. There are six posts of doctors in the districts and eight ambulances (DDC Syangja, 2072 BS, p.7). In the main cities of the district and market area, bazaars have private medicine shops or pharmacies, polyclinics and at least four private hospitals. The district is adjacent to Kaski Pokhara and Tansen Palpa; therefore, patients also go to United Mission Hospital Tansen, Palpa, Lumbini Medical College (Hospital) Prabhas Palpa and Butwal, Bhairahawa and Chitwan as well as Pokhara, Kathamandu where better medical facilities are available for medical services. Similarly, DPHO has conducted 236 immunization centers (*Khop Kendra*) (DPHO Syangja, 2071 BS, p.12) and 208 *Gaughar Clinic* (Clinic for village-households) to provide family planning, preventive service, health education and minor curative services (DPHO Syangja, 2071 BS, p.35).

4.2 Surrounding Tamkikot Hill of Syangja District

4.2.1 Location and Historical Background

Tamkikot hill (refer to figure No 4.2.1) lies in syangja district of western Nepal and erected from east-north from the Kaligandaki -A Hydroelectricity dam in Kaligandaki river and north from the Andikhola river and south from the Pindikhola stream and setibeni sila (Shaligram) . The Tamkihote Hill is situated in Nibuwakharka VDC and Pidikhola VDC.



Source: Google Earth, 2018.

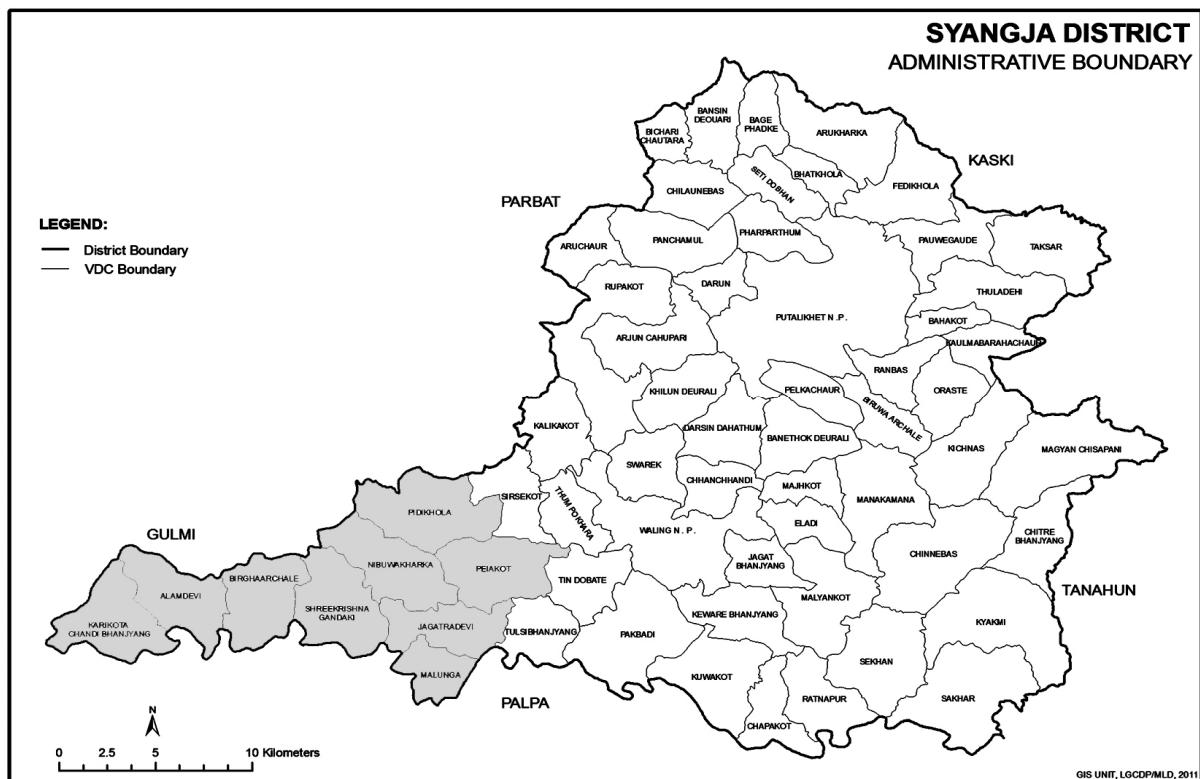
In the west of Tamkikot hill lays Lhumpek hill and Gulmi district and north Parbat district which has approximately 1740m high altitude (According to Google Earth, 2018). The surrounding of Tamkikot hill in Syangja district is taken here nine VDCs for the study area (refer figure No 4.2.2). The Siddhartha Highway dissects and runs through Jagatradevi and Malunga VDCs. The study area was taken from the west of Jagatradevi and Malungga VDCs where Magars have living from ancient times. They speak their own language. This area lies southwest on the map of Syangja district.

The history of the study area is not clear, however, the area has cultural and historical value. The Alamthān (/devi) is the historical place and connected with the origin of ancestors of former Kings Shah Dynasty and *Thakuris*. They worshiped kulpujā (ancestral god) at Almadevi with Magars. In Alamdevi Shrine, the priest is the Magar till the date. The local

peoples say stories of the kingdom of Tamkikot and the king’s family, however, there are not any clear facts till the date.



Source: Google Earth, 2018.



Source: <https://i0.wp.com/umeshg.com.np/wp-content/uploads/2017/08/Syangja.jpg> (Aug 18, 2018)

In Kirant period and Lichhavi period of history, there is no doubt that the study area was a part of the ancient Nepal Kingdom. After the fall of Lichhavi, the area belonged to Singja

Kingdom. From the establishment of the Sen Dynasty kingdom in Palpa, it belonged to Palpa Kingdom. When 'Sen Dynasty' became weak and the establishment of Baise and Chaubise kingdoms in the Magarant area, it belonged to Bhirkot kingdoms and Garau Kingdoms until the Nepal unification process reached the surrounding Tamkikot hills. Even though the study area is near the historical kingdoms of Argha Khanchi or Gulmi or Parbat, the study area could not belong to those kingdoms because the Magar language was destroyed. However, in Syangja, the majority of native Magars speak their own language. Therefore, after Sen Dynasty weakening, the study areas belonged to Bhirkot and Garahun Kingdoms in the medieval period of Nepalese history.

4.2.2 Status of Caste/Ethnicity in Surrounding Tamkikot Hill

The surrounding of the Tamkikot hill is the main habitat of the Magars from ancient times and table 4.4 shows the caste/ethnicity-wise population distribution of the study area.

Table 4.4: Ethic/Caste wise Population Distribution of the Study Area

Caste/ Ethnicity	VDC	VDC	VDC	VDC	VDC	VDC	VDC	VDC	VDC	Total	%
	1	2	3	4	5	6	7	8	9		
Chhetri	49	24	243	173	38	81	27	560	137	1332	2.76
Bahun- Hill	867	1900	577	2986	2041	1577	2531	2110	4238	18827	39.04
Magar	2456	1847	2359	3457	851	1864	1712	1082	3190	18818	39.02
Tharu	0	0	0	35	0	0	0	0	13	48	0.10
Tamang	0	0	0	15	17	0	0	0	0	32	0.07
Newar	0	20	191	711	89	0	115	33	155	1314	2.72
Muslim	0	0	0	120	0	0	0	0	27	147	0.30
Kami	341	510	385	563	148	303	692	477	330	3749	7.77
Gurung	0	0	19	201	0	0	97	230	0	547	1.13
Damai/ Dholi	121	372	52	268	28	0	132	213	112	1298	2.69
Thakuri	0	0	0	11	0	0	0	0	0	11	0.02
Sarki	0	121	97	42	0	0	89	161	366	876	1.82
Sanyasi/ Dashnami	0	0	0	13	0	0	0	0	0	13	0.03
Bahun -Terai	0	0	0	0	0	0	132	0	0	132	0.27
Gharti/ Bhujel	0	281	0	29	0	37	200	67	60	674	1.40
Bote	0	26	17	0	0	0	0	0	124	167	0.35
Terai Others	0	0	0	14	0	0	0	0	0	14	0.03
Others	10	16	2	62	18	13	21	23	63	228	0.47
Total	3844	5117	3942	8700	3230	3875	5748	4956	8815	48227	100

Note : VDC 1 = Alamdevi, 2= Birgha, 3= Chandibhanjyang, 4 = Jagatradevi, 5 = Malungga, 6 = Nibuwakharka, 7 = Pelakot, 8 = Pindikhola, 9 = Shreekrishna Gandaki
Source : CBS 2011-Table developed by researcher

The table 4.4 shows that the majority population of the study area is Brahmin and Magars. In the study area, Kami (7.77%) is in the third position, Chhetri (2.76%) has the fourth position, Newar (2.74%) ranks in the fifth position, Damai/Dholi (2.69%) has the sixth position, Sarki (1.82%) in the seventh, Gharti/Bhujel (1.40%) eighth position, and Gurung (1.40%) lies in the ninth position. In the study area, the population of other regions' ethnic groups was also found with the development of infrastructure of road and transport, other constructions and market. In Amaladevi VDC, Chandibhanjyang VDC, Jagatradevi VDC, Nibuwakharka VDC and Shreekrishna Gandaki VDC have Magar population in the first position and the rest of all VDCs have the second position.

4.2. 3 Status of Language Spoken in Surrounding Tamkikot Hill

In the study area, there is a multi-lingual population distribution. Magar language is also the major language in the study area, however, the number of Magar language speakers are decreasing every year. The migration, national policy and practices of language, media, modernization and westernization cause to decrease of indigenous Magar language in the surrounding of Tamkikot hill of Syangja district. The distribution of the language is shown in table 4.5:

Table 4.5: Mother Tongue-wise Population Distribution of the Study Area

Caste/ Ethnicity	VDC	VDC	VDC	VDC	VDC	VDC	VDC	VDC	VDC	Total	%
	1	2	3	4	5	6	7	8	9		
Nepali	1,410	3,332	1,389	4,415	2,315	2,193	5,020	3,952	5,650	29,676	61.53
Maithili	-	-	-	12	-	-	-	-	13	25	0.05
Bhojpuri	-	-	-	32	13	-	-	-	-	45	0.09
Tharu	-	-	-	21	-	-	-	-	13	34	0.07
Newar	-	20	184	688	85	-	-	18	79	1,074	2.23
Magar	2,419	1,747	2,311	3,260	813	1,678	681	749	3,003	16,661	34.55
Gurung	-	-	19	186	-	-	28	216	-	449	0.93
Urdu	-	-	-	35	-	-	-	-	-	35	0.07
Hindi	-	-	-	17	-	-	-	-	-	17	0.04
Bote	-	-	-	-	-	-	-	-	24	24	0.05
Others	15	18	3	34	4	4	19	21	33	151	0.31
Not reported	-	-	36	-	-	-	-	-	-	36	0.07
Total	3844	5117	3942	8700	3230	3875	5748	4956	8815	48227	100

Note : VDC 1 = Alamdevi, 2= Birgha, 3= Chandibhanjyang, 4 = Jagatradevi, 5 = Malangga, 6 = Nibuwakharka, 7 = Pelakot, 8 = Pindikholo, 9 = Shreekrishna Gandaki

Source : CBS 2011/table develop by researcher, 2015

The table 4.5 shows majority population speaks Nepali (61.53%) and followed by the Magar (34.55%) language. Newar (2.23%) holds the third position in the study area. In Alamdevei VDC and Chandibhanjyang VDC, the Magar language is in the first position and the remainder VDCs have the second position of the Magar language. The indigenous knowledge regarding ill-health medication is found preserved in the Magar language.

4.2.4 Education Facilities in Surrounding Tamkikot Hill

In the study area, there were both governmental and institutional (private) schools, colleges for higher education. The distributions of education facilities are shown in table 4.6:

Table 4.6: Distribution of Educational Facilities of the Study Area

VDC	ECD/ Shishu		Primary		Lower- Secondary		Secondary		Higher Secondary		Campus/ College
	Govt.	Pvt.	Govt.	Pvt.	Govt.	Pvt.	Govt.	Pvt.	Govt.	Pvt.	
Jagatradevi	10	3	7	-	2	-	-	1	1	2	1
Malungga	3	2	3	2	-	-	-	-	1	-	1
Pelakot	6	-	7	-	-	-	1	-	2	-	-
Pidikhola	9	-	7	-	2	-	1	-	1	-	-
Nibuwakharka	10	-	7	-	2	-	1	-	1	-	-
Krishnagandaki	5	2	5	1	1	-	3	1	3	-	1
Birgha	8	1	7	-	-	-	-	1	1	-	1
Alamdevi	5	1	6	1	1	-	-	-	1	-	-
Chandi Bhanjyang	6	-	5	-	1	-	1	-	-	-	-
Total	62	9	54	4	9	-	7	3	11	2	4

Source: DEO Syangja (2069 BS), Syangja Shaichhik Darpan Vol 13, Number 12.

The table 4.6 shows that in the study area, 9 VDCs have 54 primary, 9 lower secondary, 7 secondary, 11 higher-secondary schools run by the community under the government funds. However, 4 primary, 3 secondary, 2 higher secondary schools were found institutional (private) schools. Among them, 62 community schools and 9 institutional (private) schools were running ECD (or Shishu) classes for underage children under the age of five years. The private schools are in the market (bazaar) areas such as Galyang Bazar, Mirmi Bazar, Malungga Bazar, Birgha bazaars where transportation and density of population are high. Comparatively, the distribution of schools and educational institutions was seen sufficient, but there were difficulties to go to schools for children due to the geographical situation from one village to another village. Despite these educational facilities, there was a lack of vocational education institutions.

4.2.5 Health Care Facilities in Surrounding Tamkikot Hill

In the study area, both the governmental and private health sectors (Bio-medicine) were providing health care facilities to local peoples. The Malungga VDC has a primary health

care center. Birgha VDC and Pindikholā VDC have health posts and the remaining VDCs Jagtradevi, Nibuwakharka, Pelakot, Shreekrishna Gandaki, Alamdevi and Chandibhanjyang have sub-health posts from the government (DDC Syangja 2072 BS, Field Survey, 2015). From the private sector, in Galyang Bazar and Mirmi Bazar, each of them has one private hospital, one NGO community hospital at Galyang Bazaar providing modern (Bio-medical) services. In the study area, Pidikhola Bazaar of the Pidikhola VDC, Galyang Bazar of Jagtradevi VDC, Malungga Bazar of Malungga VDC, Mirmi bazaar of Shrikrishnagandaki VDC, Birgha Bazar of Birgha VDC have private medicine shops in several numbers. Similarly, other places of small markets or villages have medical shops in every VDCs. In Galyang Bazaar of Jagtradevi VDC, there are also Acupuncture healthcare services and Ayurvedik medicine shops. In addition, traditional healers or (lama) shamans are available in every village, and astrologers, priests, faith healers are also found in the study area.

4.2.6 Local Shrines and Faith Healings

The local shrines are related to local religious belief, some historical myths, well-being and well-fortune. Local people including Magars, do religious or cultural vow to offers worship or sacrifice (*Bhokal*) to the local shrines when they fall in illness and misfortune. After doing the promise of *Bhokal*, they visit the shrine and do worship or give sacrifices as promised. By doing this, they feel peace and mentally healthy. Here is mentioned some major shrines, which the majority of the population follows and related with ill-health and well-being:

Rhedi: Rhedi is also called 'Ridi' and Ruru Chhetra. "Rhedi" is the pronunciation of old generation Magars; which is original and meaningful in the Magar language. 'Ridi' is corrupted from the Rhedi, because it is difficult to pronounce bready sounds for Indo-Aryan language speaking population. The *Ruru-Chetra* is the influence of Indianization and Sanskritization. 'Rhee' is a kind of baboo (*Bet*), and 'di' means water in Magar Language. Rhedi lies on the bank of Kaliriver where Rhidikhola ends. The shrine is famous for fairs or exhibitions and cultural worships on *Saune Thuli Ekadasi*, *Kartike Thuli Ekadashi*, *Maghe Sakarati*, *Baisakhe Sakarati*. The peoples do *Bhākal* (promise for god) for health and well beings, and better fortune; so, they attend for worships and offerings. The Magars go there for ancestral remembrance worship (pitrikarya/Shradda; in Magar culture Mudhi Dake) in Maghe Sakarati festival to keep happy for the ancestral soul.

Alam-Thān(devi): Alam-thān is also called Alamdevi. The shrine is a historical place that is connected with the ancestors of the former King of Nepal and the Magars. In the Magar language, *Alamdevi* is corrupted from *ālākon+lām+thān* which means another path or way or

philosophy's deity and or staying another road. The term 'devi' is borrowed from the Indian Hindu instead of thān Magar language word. There, a clan of former Kings of Nepal, some clan of Thakuri and some clan of Magar do *Kul puja* (clan worship remembering ancestor). This is also an ancient fort (Jong/K Kot) where worship of weapons and warfare (*khonda*) is also done. In past, there were no images or statues of deity or god in the *Thān* (shrine) and people used to worship natural objects, however, recently there is an influence of Indianization and Sanskritization. The local public believe that the god-spirit of the Alamdevi could remove illness and misfortune and gives prosperity if regular worshipping is carried out.

Andimohan: Andimohan is a bank of the river where Andhikhola (*āngdi*) ends. This is named from 'āngdi molhcha' word of Magar Language. The ritual and cultural activities occur at the *Saune Thuli Ekadasi*, *Kartike Thuli Ekadashi*, *Maghe Sakarati*, *Baisakhe Sakarati* but due to the construction of Kaligandaki-A hydropower dam and lake, the bank of the river is sunk and no space to celebrate ritual festivals. Therefore, it is shifted to Setibeni, Rhidi and Ramdi.

Setibeni: The local Magars pronounce it as *syādibini* and here is a huge black stone locally called *shilā* or *silālung* and in Sanskrit Shaligram. Nowadays, it can be reached from Mirmi Andihohan traveling seven kilometers in steamer or boat. This is also famous like Rhedi (ridi) for fairs or exhibitions and cultural worships on *Saune Thuli Ekadasi*, *Kartike Thuli Ekadashi*, *Maghe Sakarati*, *Baisakhe Sakarati* and it also being developed as a cultural and religious place. In Kattike Thuli Ekadashi festival, the dancers of *ghāntu* traditional folk dance and faith healing culture go to Setibeni to fulfill the ritual of *ghāntu*. They bathe in the *Ghāntu di* and Kaligandaki, Gurumā's sings songs of *ghāntu* and fulfill the rituals. Local people including Magars believe that being happy, *Setibeni-Shilā* prevents them from illness and misfortune.

Tamkikot: Tamkikot is also a Shrine; the locals believe that there is a settlement of god, therefore, worshipped therein during Dashain festival period. There is a belief that if the god of Tamkikot becomes happy, he will protect us from us illness and misfortune.

Bhalthumkot: Bhalthumkot is adjacent to Tamkikot shrine. This is an ancient fort and established as a kot (fort) where weapons and war-fares are worshiped in Chaite Dashain and Badā Dashain doing sacrifices. The history of the place also connected with Tamkikot Shrine. Previously, the locals used to worship a stone near the temple, later on, a temple was constructed and established the Kalika Mandir in the kot (fort). The *Khonda* (a kind of sword) is also worshiped. The local people believe that if the god or goddess becomes angry due to

any reason, they can cause illness and misfortune, and the god can send a tiger into the village to eat cattle.

Akaladevi: Akaladevi goddess is related to reproductive health and worshiped in a stone-shaped as if giving childbirth to women. Akaladevi shrine lies in Pelakot VDC, Ghurunkhan village. If the goddess becomes angry, the Akaladevi goddess can cause a problem in childbirth during a delivery period, miscarriages, infertilities and Gynaecological diseases. Therefore, the local public worships the shrine and do promises of offering to the shrine if there comes any Gynaecological and reproductive health problems.

Balām Devi: Balāmdevi lies at *Balām* Village of Jagatradevi VDC and is also called Jagatradevi. Previously, there was a stone instead of the image of God to be worshiped, but later on, Jagatradevi's image and temple were established which became famous from the Jagatradevi temple. The locals believe that the god-spirit of the *Balāmdevi thān* can prevent illness, misfortune and fulfil the wishes of the public. Therefore, they do worship, make a promise to worship and sacrifice chicken and animals.

Garangdi Kot: Garandi Kot is also related to the other Kots like Bhalthumkot and worshiped on Chaite Dasai and Bada Dashain festival when war-fares and Khonda are worshipped. Kalikadevi and Jagatradevi images of gods are built like in other Kots of the Magarant, which is evidence of the influence of Hinduism in the Magar villages. Locals have a belief in the god-spirit which can prevent illness, misfortune and bring success in about what was wished with the god.

Ramdi: Ramdi lies in between Malhungga VDC of Syangja district and Palpa district. Ramdi is also famous as the Rhidi (Ridi) shrine. Ramdi belongs to the Magar language word (Rang - Big, mature and di- water), however, due to the influence of Sanskritization, nowadays, it is also called 'Ramnadi'. The shrine is famous for fairs or exhibitions and cultural worships on Saune Thuli Ekadasi, Kartike Thuli Ekadashi, Maghe Sakarati, and Baisakhe Sakarati. And there is also Siddhathan where daily worship is conducted. The locals believe that by keeping happy with the shrine's god and goddess, they would get relief from the illness, misfortune and succeed in what they wished with the god of the shrine.

4.3 Characteristics of the Studied Population

Health, illness and medication practices are social phenomena and these variables are social structures (social units) that are functioning the society. This variable varies according to socio-cultural, socio-economic and social factors of the population. Demographical data shows a situation of the society and explores a glimpse of the society within the given geography; health problems and solutions could be found within the population demography. To do social and health research population should be needed and population is the basic foundation to become society, ethnicity etc. In this section; age, sex, marital status, language, family structure, profession etc demographic data are presented to support the study.

4.3.1. Situation of Studied Population

In this study, 636 respondents were selected randomly from one respondent from each household of the VDC's surrounding Tamkikot hill of the Syangja district have with equal gender basis i.e. 318 respondents were female and 318 respondent were male. The sex and age composition of the respondents are shown in table 4.7:

Table 4.7: Age and Sex-wise Population Distribution of Respondents

Age of Respondent	Sex of Respondent				Total	Total %
	Female	% Female	Male	% Male		
Up to 25 (22-25)	21	3.30	19	2.99	40	6.29
26 - 35	74	11.64	55	8.65	129	20.28
36 - 45	79	12.42	66	10.38	145	22.80
46 - 55	58	9.12	72	11.32	130	20.44
56 - 65	50	7.86	61	9.59	111	17.45
66 & above	36	5.66	45	7.07	81	12.74
Total	318	50.00	318	50.00	636	100.00

Source: Field Survey 2015

The table 4.7 shows that interviewed respondents were above 21 Years old and a higher percentage (22.80%) of respondents were from the age group 36-45 years old and least (6.29%) from the under 25 years old. The senior citizen respondents were 12.74% in the study. Gender wise male and female were equal participated in the interview of the study.

Household Population

In the study area, the total population is 48,227 according to CBS 2011. Among them, population of Magars is 18,818 (male 8,255 and female 10,563). It covers 39.02% of the total population of study area. For this study, 636 Magar households were selected randomly where the total population is 3,783 among them 1928 or 50.96% are females and 1855 or 49.04% are males. The age and sex-wise population is shown in table 4.8:

Table 4.8: Distribution of Age and Sex-wise Household Population in the Study

Age	Sex				Total	% Total
	Female	% Female	Male	% Male		
Under 5 Yrs	131	3.46	147	3.89	278	7.35
06 -15 Yrs	317	8.38	341	9.01	658	17.39
16 - 25 Yrs	472	12.48	394	10.42	866	22.89
26 - 35 Yrs	343	9.07	385	10.18	728	19.24
36 - 45 Yrs	229	6.05	233	6.16	462	12.21
46 - 55 Yrs	172	4.55	141	3.73	313	8.27
56 - 65 yrs	144	3.81	116	3.07	260	6.87
66 Yrs & above	120	3.17	98	2.59	218	5.76
Total	1928	50.96	1855	49.04	3783	100.00

Source: Field Survey, 2015.

The table 4.8 shows that the population of studied households were higher percentage (22.89%) of age groups 16-25 years old and least (5.76%) were senior citizens i.e. age group of 66 & above years old. In sex-wise composition female (50.96%) higher than male (49.04%), however, in new generation (under 15 years (under 5 yrs+06-15 yrs) old age groups); the males (12.90%) were higher than females (11.84%). The freely available facilities of abortion and passion of male child due to mainstream culture of the country helps to increase male child in the community.

4.3.2. Marital Status

Marriage is a social institution and it accelerates the human society and continuity of human beings from reproduction and family formation which is adopted by human society from a long time ago. The marital status of the respondents is shown in table 4.9:

Table 4.9: Marital Status and Sex-wise Population Distribution of Respondents

Marital Status of Respondent	Sex of Respondent				Total	% Total
	Female	% Female	Male	% Male		
Married	227	35.69	295	46.38	522	82.08
Unmarried	5	0.79	10	1.57	15	2.36
Single (Widow/Widower)	85	13.36	13	2.04	98	15.41
Divorced	1	0.16	0	0.00	1	0.16
Total	318	50.00	318	50.00	636	100.00

Source: Field Survey, 2015

The table 4.9 shows that married respondents were 82.08% among them 35.69% were females and 46.38% males. The unmarried respondents were 2.36% with 0.79% females and 1.57% males. Furthermore, single (widow/widower) respondents were 15.41% among them

13.36% were females and 2.04% male. Females were more single (widow) than the males by 11.32%. And only 0.16% of female respondents were divorced.

The age and sex-wise distribution of the marital status of the respondents are presented in table 4.10:

Table 4.10: Distribution of Age and Sex-wise Marital Status of Respondents

Age		Married			Unmarried			Single (Widow/Widower)			Divorced			G Total
		Fem	Male	Total	Fem	Male	Total	Fem	Male	Total	Fem	Male	Total	
Under 25	Count	18	12	30	3	7	10	0	0	0	0	0	0	40
	%	2.83	1.89	4.72	0.47	1.10	1.57	0.00	0.00	0.00	0.00	0.00	0.00	6.29
26 - 35	Count	69	52	121	2	3	5	3	0	3	0	0	0	129
	%	10.85	8.18	19.03	0.31	0.47	0.79	0.47	0.00	0.47	0.00	0.00	0.00	20.28
36 - 45	Count	71	65	136	0	0	0	8	1	9	0	0	0	145
	%	11.16	10.22	21.38	0.00	0.00	0.00	1.26	0.16	1.42	0.00	0.00	0.00	22.80
46 - 55	Count	34	70	104	0	0	0	23	2	25	1	0	1	130
	%	5.35	11.01	16.35	0.00	0.00	0.00	3.62	0.31	3.93	0.16	0.00	0.16	20.44
56 - 65	Count	23	56	79	0	0	0	27	5	32	0	0	0	111
	%	3.62	8.81	12.42	0.00	0.00	0.00	4.25	0.79	5.03	0.00	0.00	0.00	17.45
66 & above	Count	12	40	52	0	0	0	24	5	29	0	0	0	81
	%	1.89	6.29	8.18	0	0	0	3.77	0.78	4.56	0	0	0	12.74
Total	Count	227	295	522	5	10	15	85	13	98	1	0	1	636
	%	35.69	46.38	82.08	0.79	1.57	2.36	13.36	2.04	15.41	0.16	0.00	0.16	100.00

Source : Field Survey, 2015

The table 4.10 shows that the higher percentage of age-group wise married was found 36-45 years old age group, single (widow/widower) in the age group 56-65 years old age groups. Similarly, sex-wise, there is a difference in marriage pattern in age, in Magar society, females are found early marriage than male and widower are less than widow due to the influence of Hindu patriarchy system.

Marriage-age Pattern

Marriage and age are interrelated health. Generally, early age marriage is not good from the perspective of sound health. Therefore, WHO and the Government of Nepal are implementing health awareness on marriage after 20 years of age. In the context of Nepal, there were early childhood marriages in past and such types of conservative culture still practicing according to their community's norms, values and rituals, however, nowadays those practices are rare. There were so many folk songs talking about *Sohra barse baisaor* age of marriage in sixteen. Furthermore, Nepal's law also allows sexual relationship after 16

in *Muluki ain*, however, the marriage age is at least 18, but most of the communities seem to violate this rule and follow their customs. The age pattern of marriage has presented in table 4.11:

Table 4.11: Age at First Marriage in Respondent's Family/ Marriage Patterns

Age	Married in More than 10 Years ago						Married in Past 10 Years					
	Female		Male		Total		Female		Male		Total	
	freq	%	freq	%	freq	%	freq	%	freq	%	freq	%
Under 15	124	16.85	14	2.31	138	10.28	37	9.59	6	1.59	43	5.63
16 - 18	272	36.96	91	15.02	363	27.05	112	29.02	31	8.20	143	18.72
19 - 20	213	28.94	143	23.60	356	26.53	102	26.42	72	19.05	174	22.77
21 - 25	111	15.08	282	46.53	393	29.28	90	23.32	178	47.09	268	35.08
26 - 30	16	2.17	61	10.07	77	5.74	42	10.88	86	22.75	128	16.75
31 - 35	0	0.00	14	2.31	14	1.04	3	0.78	4	1.06	7	0.92
36 & Above	0	0.00	1	0.17	1	0.07	0	0.00	1	0.26	1	0.13
Total	736	100	606	100	1342	100	386	100	378	100	764	100

Source : Field Survey, 2015

The table 4.11 shows that in the study of the Magars, total having marriage before 10 years ago (before 2005AD) has found 1,342 among them 736 were females and 606 males. Similarly, after 10 years (after 2005 AD) there have found 764, among them 386 were females and 378 are males in 636 households of the study area. Furthermore, under 25 years, the majority of the Magars were found first married, but in the last 10 years, it has slightly changed and increased first married age. There was found child marries among the Magars, however, before 10 years ago (before 2005 AD) has slightly changed and reduced in child marries but not stopped. Married under 15 years old age groups, females were found higher than males.

4.3.4. Educational Status

Education is light of life which makes a clear vision and makes it easier to sustain life and it is necessary to the development of a nation and society. Education increases awareness in the community and makes commitments to fulfil responsibilities being a human being. However, in Nepal, the role of education in nation-building process is debatable. Since education is an essential social process in human life, people get education formally and informally from society. The formal education status of the respondents has shown in the table 4.12:

Table 4.12: Education Level *Sex*Age of Respondent Cross-tabulation

Age	Sex	Education Level of Respondent												Total	
		Illiterate		Literate/ Primary		Lower Secondary		Secondary		Certificate Level/+2		Bachelor & above			
		f	%	f	%	f	%	f	%	f	%	f	%	f	%
Under 25	Female	0	0.00	0	0.00	2	0.31	11	1.73	4	0.63	4	0.63	21	3.30
	Male	0	0.00	0	0.00	0	0.00	6	0.94	12	1.89	1	0.16	19	2.99
	Total	0	0.00	0	0.00	2	0.31	17	2.67	16	2.52	5	0.79	40	6.29
26 - 35	Female	1	0.16	17	2.67	25	3.93	22	3.46	7	1.10	2	0.31	74	11.64
	Male	0	0.00	10	1.57	14	2.20	19	2.99	6	0.94	6	0.94	55	8.65
	Total	1	0.16	27	4.25	39	6.13	41	6.45	13	2.04	8	1.26	129	20.28
36 - 45	Female	4	0.63	49	7.70	18	2.83	7	1.10	1	0.16	0	0.00	79	12.42
	Male	0	0.00	22	3.46	17	2.67	24	3.77	2	0.31	1	0.16	66	10.38
	Total	4	0.63	71	11.16	35	5.50	31	4.87	3	0.47	1	0.16	145	22.80
46 - 55	Female	15	2.36	40	6.29	1	0.16	2	0.31	0	0.00	0	0.00	58	9.12
	Male	6	0.94	33	5.19	9	1.42	18	2.83	5	0.79	1	0.16	72	11.32
	Total	21	3.30	73	11.48	10	1.57	20	3.14	5	0.79	1	0.16	130	20.44
56 - 65	Female	25	3.93	25	3.93	0	0.00	0	0.00	0	0.00	0	0.00	50	7.86
	Male	5	0.79	36	5.66	13	2.04	4	0.63	2	0.31	1	0.16	61	9.59
	Total	30	4.72	61	9.59	13	2.04	4	0.63	2	0.31	1	0.16	111	17.45
66 & above	Female	26	4.09	10	1.57	0	0	0	0	0	0	0	0	36	5.66
	Male	7	1.1	33	5.19	2	0.31	2	0.31	1	0.16	0	0	45	7.07
	Total	33	5.19	43	6.77	2	0.31	2	0.31	1	0.16	0	0	81	12.74
Grand Total	Female	71	11.16	141	22.17	46	7.23	42	6.60	12	1.89	6	0.94	318	50.00
	Male	18	2.83	134	21.07	55	8.65	73	11.48	28	4.40	10	1.57	318	50.00
	G. Total	89	13.99	275	43.24	101	15.88	115	18.08	40	6.29	16	2.52	636	100.00

Source : Field Survey, 2015

The table 4.12 shows that 13.99% of respondents were found illiterate among them 11.16% were females and older age groups have a higher percentage in illiteracy. The majority of respondents (43.24%) have primary level or literate education level and only 2.52% of respondents had in higher education. Having higher education respondents, the majority were below 35 years old and the majority of respondents were non-graduate in the study area.

Furthermore, in the household population of the respondents, the education status is portrayed glimpse of education level in the Magar society on table 4.13:

Table 4.13: Distribution of Educational Status of Household Population

Education Level	Female		Male		Total	
	Count	%	Count	%	Count	%
Illiterate	219	11.36	74	3.99	293	7.75
Literate/Primary	571	29.62	505	27.22	1076	28.44
Lower Secondary	387	20.07	382	20.59	769	20.33
Secondary	347	18.00	430	23.18	777	20.54
Certificate/+2	242	12.55	306	16.50	548	14.49
Bachelor & Above	70	3.63	73	3.94	143	3.78
Underage Children to go School	92	4.77	85	4.58	177	4.68
Total	1928	100.00	1855	100.00	3783	100.00

Source: Field Survey 2015

The table 4.13 shows that total illiterate population was 7.75% where females were 11.36% and males 3.99%. The difference was found 7.37% between males and females. Hence, the females have found more illiterate than males. The majority population had primary or literate level education. Similarly, cumulatively majority population were under higher secondary (+2) education level. In higher education, only 3.78% population was found in the study area. However, in CBS 2011, the Magar have 1.34% in higher education (CBS 2011). It shows the Magars of Syangja are more educated than other places. However, there are socio-cultural and socio-economic causes prohibiting Magars from achieving higher education, for example, culture and economic dependence on Gurkha soldiers for foreign countries, foreign employment, and subsistence agricultural economy. In this way, they are not eager to reach in the mainstream (bureaucracy and politics) of the country. They have over satisfaction in the existing situation. On the other hand, there is not multicultural and multi-lingual education in the mainstream of the nation. Therefore, mother tongue and ancestor's culture are also playing a role to create a barrier in school education. In schools, it is generally taught in Nepali language or English medium; and the curricula are based on higher caste culture or the western culture. Therefore, in childhood, the cognition of the majority of Magar students dies in school, and so they become weak in higher education¹. The guardians were not aware of the multi-cultural and multi-lingual education in household education. That's why there come obstacles to get higher degrees for the majority of Magar students. The proper education helps to know socio-cultural history in a scientific way, heritages of the nation and Magars, health and illness (based on a conversation with key informants).

¹ Based on conversation with KIs teacher Pritha Bahadur Rana of Birgha VDC, Nar Bahadur Rana (VDC chairman of Alamdevi VDC), Wum Maya Thapa (Local teacher of Balam village), Lal Bahadur Thapa (Social worker of Muti village)

4.3.5 Status of Language Spoken in Studied Population

Magars have their own language which is called Magar language which has three dialects as (1) *Magar Dhut* (2) *Magar Kham/Pang* and (3) *Magar Kaike*. In Surrounding Tamkikot hill of Syangja district, the Magars speak *Magar dhut* which used to be called *Magar kura* in past. The Magar language is a heritage of Nepal and is conserved by the Magars, however, there has been an inconvenient situation. That's why, according to CBS 2011, only 41.77% of the total Magars population can speak their own language and the remainder all were compelled to forget their own language due to several reasons. The study area is the Magar language-speaking zone. The situation of Magar language as the mother tongue of the respondents of the study area is shown in table 4.14:

Table 4.14: Distribution of Mother Tongue and Sex-wise Population of Respondents

Mother Tongue of Respondent	Sex of Respondent				Total	
	Female		Male			
	Frequency	Percentage	Frequency	Percentage	Frequency	Percentage
Magar	294	46.23	311	48.90	605	95.13
Nepali	24	3.77	7	1.10	31	4.87
Total	318	50.00	318	50.00	636	100.00

Source : Field Survey, 2015

The table 4.14 shows that 95.13% of respondents were found having Magar language as their mother tongue where 46.23% were females and 48.90% males. Only, 4.87% of Magars have their mother tongue as Nepali as they have forgotten their own language counting 3.77% females and 1.10% male respondents. Here, female respondents of forgetting their Magar language has been found higher in number that can be analyzed that a significant number of Magars are going to lose their language because females are the mothers who teach this mother tongue to their offspring.

Degradation Trend of Speaking Mother Tongue

The study area is a highly Magar language speaking area since the ancient era, most of the Magar villages and settlements used their own language. However, it is observed that a few households of the Syālbās village of Pindikholā VDC, Jaluke & Rupakhani villages of Nibuwākharka VDC and Kapurdi, Khani villages of Pelākot VDC's Magars have totally forgotten their ancestor's language and speak Nepali as their mother tongue in the Magar tone. The Magar language forgetting pattern of the study area is shown in table 4.15:

Table 4.15: Status of Magar Language Skill and Forgetting Pattern in the Study

Skill for Magar Language	Frequency	Percentage
Able to Speak	3377	89.27
Just Understand	280	7.40
Don't Understand	126	3.33
Total	3783	100.00

Source: Field Survey 2015

The table 4.15 shows that in the total population of 3,783 from 636 households under study, 89.27% Magars were able to speak Magar language. In contrast, 7.40% population was unable to speak their mother tongue but just understand and those populations were school students which is a sign of forgetting their mother tongue in the future. The 3.33% of the total population has forgotten their own mother tongue in the Magar language-dominated area. It indicates that the Magars are going to forget their own ancestor's language. Similarly, it is observed that many pure Magar language words are replaced by Nepali, Hindi and English words.

4.3.6 Religious Status of Respondents

Nepal has diversity in religion, however, dominated by Hindu religion. It is the birthplace of Lord Buddha who initiated Buddhist philosophy in South Asia and later spread all over the world, but Buddhist Philosophy followers in Nepal are in the minority as recorded by CBS 2011. The status of the religions of the respondents under study is shown in table 4.16:

Table 4.16: Distribution of Religion of Respondent in the Study

Religion	Sex of Respondent				Total	
	Female		Male			
	Frequency	%	Frequency	%	Frequency	%
Traditional or Animist	82	12.89	64	10.06	146	22.96*
Buddhist	44	6.92	41	6.45	85	13.36
Hindu	169	26.57	187	29.40	356	55.97
Christian	3	0.47	4	0.63	7	1.10
Atheism/Nāstik	0	0.00	2	0.31	2	0.31
Don't Know	20	3.14	20	3.14	40	6.29
Total	318	50.00	318	50.00	636	100.00

* Here, traditional or animist means, the people following religious culture from the ancient time (*sanātan*) and worshiping the natural objects and ancestors in the village which has not a specific name.

Source: Field Survey, 2015,

The table 4.16 shows that the majority of Magar respondents (55.97%) of the study area follow the Hindu religion and the least respondents (1.10%) follow Christianity. However,

Christianity is increasing due to ethnic discrimination. Similarly, Buddhism and Atheism/*Nāstik* were introduced due to political activism. Due to ethnic discrimination in the mainstream of the nation, following the Buddha religion truly is found emerging in the study area. However, they are found losing collective identity and their culture, language, indigenous knowledge of ill-health and healings through the new religions or nation's religion.

4.3.7 Family Structure

In Nepal, the trend of joint family was the pride subject in earlier society, especially, in indigenous ethnic groups, but it is changing. The distribution of types of family among the respondents of study areas is shown in table 4.17:

Table 4.17: Distribution of Types of Family of Respondents

Types of Family	Sex of Respondent				Total	
	Female		Male			
	Frequency	Percentage	Frequency	Percentage	Frequency	Percentage
Unitary	151	23.74	127	19.97	278	43.71
Joint	167	26.26	191	30.03	358	56.29
Total	318	50.00	318	50.00	636	100.00

Source: Field Survey, 2015

The table 4.17 shows that 43.71% of respondents' households were unitary families. Among them, 23.74% were females and 19.97% male respondents living in unitary families. Similarly, 56.29% of respondents' households were in joint family and among them, 26.26% were female and 30.03% male respondents. Hence the majority of respondents were found living in a joint family. However, a changing pattern of joint family to unitary family was observed due to changes of the Nepalese society, nation and global.

4.3.8 Occupation

Occupation is the economic earning for subsistence family livelihood and develops carrier of family members, pays government taxes and runs socio-cultural aspects in the society being a social member. The occupation status of the respondents is presented in table 4.18:

Table 4.18: Distribution of occupation of respondents

Occupation		Sex of Respondent		Total
		Female	Male	
Agriculture	Count	209	129	338
	% within Sex	65.7%	40.6%	53.1%
Job/ Service in Nepal	Count	4	24	28
	% within Sex	1.3%	7.5%	4.4%
Construction/ Maintenance Works	Count	0	20	20
	% within Sex	0.0%	6.3%	3.1%
Business	Count	15	18	33
	% within Sex	4.7%	5.7%	5.2%
Foreign Employment	Count	0	32	32
	% within Sex	0.0%	10.1%	5.0%
Job in India	Count	0	23	23
	% within Sex	0.0%	7.2%	3.6%
Housewife	Count	45	0	45
	% within Sex	14.2%	0.0%	7.1%
Ex-Army/Pensioner/Army in India or UK	Count	43	64	107
	% within Sex	13.5%	20.1%	16.8%
Others	Count	2	8	10
	% within Sex	0.6%	2.5%	1.6%
Total	Count	318	318	636
	% within Sex	100.0%	100.0%	100.0%

Source: Field Survey, 2015.

The table 4.18 shows that the majority of respondents (53.1%) had agriculture occupation and the second-highest percentage of respondents had the occupation of ex-army/pensioner/ army in India or the UK (16.8%). In agriculture, female respondents were higher than males. The least occupation was others (1.6%) counting the students (1.10% or 7), social service (0.16% or 1), *wāpā* or Magar priest (0.16% or 1), *lāmā* or shaman (0.16% or 1). Furthermore, due to foreign employment and other occupations, the agriculture occupation was decreasing in the study area and occupations of spouses of foreign employers were housewives (7.1%). And 13.5% of females were pensioners as their income source.

4.3.9 Household Occupation and Income Source

Income source is needed to survive, adapt to society, and run daily life as well as to solve contingency circumstances. Household's occupation or profession is needed for income generation. Today, households with high-income sources can buy sophisticated high technology health facilities, get a good education, consumption of quality goods, but the poor cannot afford them. Migration for jobs or income sources could add a high risk in transmission of communicable diseases including STI and HIV/AIDS. Similarly, in some occupations, there are health hazards, and risks in occupational health and safety. In such situations, awareness about health and safety is required in their profession to avoid illness and possible injuries. The migration for the income sources could have an impact on socio-

cultural of the particular society. Therefore, household income sources or occupations of the family member's information could portray the health situation and socio-cultural impacts on health in the society. Among the household population 3783 of the sampled from 636 respondents' households, the 2191 population was active in economic activities. The distribution of occupation for economic activities is presented in table 4.19:

Table 4.19: Distribution of Occupation for Income Source of Magar Households

Income Source of the Family	Frequency	Percentage
Agriculture	1170	53.40
Nepal Army/Police Pension	9	0.41
Indian Ex-army Pension	186	8.49
British ex-army Pension	8	0.37
Foreign Employment (Gulf Country/Malaysia etc)	292	13.33
Foreign Employment (Iraq/Afghanistan/Conflict having Country	6	0.27
Foreign Employment (Korea/ Japan/ Europe/America etc.)	28	1.28
Teaching	43	1.96
Government Civil Service	11	0.50
Service/Job in other Sectors	40	1.83
Nepal/Army Police	41	1.87
Indian Army	49	2.24
Service/Job in India	162	7.39
Business/Shopkeeper/ Entrepreneurship	74	3.38
Mason/Carpenter etc	53	2.42
Welding/Electrician/Plumbing/Mechanic etc	4	0.18
Driving/ Bus Helper	13	0.59
British Army	2	0.09
Total	2191	100.00

Source: Field Survey, 2015.

The table 4.19 shows that the majority of household members had an occupation of agriculture (53.40%) and cumulatively foreign employment or *lāhuryā* profession or occupation had the second-highest percentage and serving within Nepal or job having within-country had very low percentage. Similarly, the profession of the British Gurkha army, pension from British Gurkha were very low due to migration to cities, Hong Kong and the UK. The rural economy of the Magars was subsistence from the foreign employment such as Gulf countries, Malaysia, Job in India and pensioners of the Indian Gurkhas soldiers. However, nowadays, the Magars have been diversified in occupation for income generation.

CHAPTER FIVE

THE MAGARS AND SOCIO-CULTURAL BACKGROUND

The chapter deals with a description of the Magars of the study area and their socio-cultural background, customary institutions, customary laws and so on as being indigenous peoples; that are directly or indirectly related to health, illness and healing practices.

5.1 Introduction

Socio-cultural background has a great role in the construction of concepts or perceptions about health, illness and medication practices. Nepal is wealthy in socio-cultural heritage diversities. The Magars are one of them. Being indigenous peoples, they have a feeling of 'we' and 'commonness' in the society. In the Magar villages of the study area, they help each other to construct houses for residents free of cost via providing skilled and unskilled labours. Similarly, they gathered to construct common properties such as village paths (*lām*), *chautāri*, public buildings, drinking water, irrigations and so on. They provide labours, money and other kinds for community works. They have an indigenous way of management system of forest and natural resources through customary/traditional institutions. They have traditional institutions such as *bhejā*, *lānghā*, *pāthebhai*, *gumasthā*, *bhailo* and other social institutions to resolve the social problems, regulate the society and ethics. Similarly, they have traditional cultural dances and songs such as *rodi*, *sorathi*, *māruni*, *jhāmre*, *ghānto*, *jhorā* and so on. They were highly civilized in the ancient era and they were developed *rodi* culture which was a club of youths for entertainment and to create new songs, dances and music. In contrast, in Nepali mainstream culture, language and social system, the Magars' socio-cultural aspects are excluded from historical period to today. The development in the national education system, media and information technology, political system, bureaucracy, health and social, infrastructures and so on are influencing to change rapidly for socio-cultural aspects of the Magars in the direction of disappearance because of the lack of safeguard measures for a long time ago in such development processes. Here, socio-cultural backgrounds that are related to health, illness and medication practices are discussed. The other aspects of the Magars are already discussed in previous chapters.

5.2 Distribution of Magar Population in the Study Area

In the study area, the distribution of Magar population is 39.02% which is the second largest population among all ethnic groups. The Magars are the indigenous people of this land and

they are living here from immemorial era to the present time. The VDC-wise population distribution of the Magars is presented in table 5.1:

Table 5.1: VDC and Sex-wise Magar Population and Household Distribution

Name of VDC	Total Population	% of Magar Population	Total Magar Population	% within Magar Population	Sex		Total HH	Average HH size	Magar HH	% of Magar HH
					Male	Female				
Alamdevi	3844	63.89	2456	13.05	1051	1405	908	4.23	581	63.94
Birgha	5117	36.10	1847	9.82	783	1064	1180	4.34	426	36.07
Chandibhanjyang	3942	59.84	2359	12.54	1012	1347	981	4.42	534	54.40
Jagtradevi	8700	39.74	3457	18.37	1546	1911	2050	4.24	815	39.77
Malungga	3,230	26.35	851	4.52	423	428	678	4.76	179	26.37
Nibuwakharka	3875	48.10	1864	9.91	819	1045	790	4.91	380	48.05
Pelakot	5748	29.78	1712	9.10	698	1014	1220	4.71	363	29.79
Pidikhola	4956	21.83	1082	5.75	474	608	1119	4.43	244	21.83
Shreekrishna Gandaki	8815	36.19	3190	16.95	1449	1741	1993	4.42	722	36.21
Total	48227	39.02	18818	100	8255	10563	10919	-	4243	38.86

Source : CBS 2011/ table developed by researcher 2015

The table 5.1 shows that the total Magar population was 18,818 in the study area. Among them 8,255 were males and 10,919 were females. Chandibhanjyang VDC and Alamdevi VDC have a majority of the Magar population. In Jagtradevi VDC, Shreekrishna Gandaki VDC, Alamdevi VDC and Chandibhanjyang VDCs have more density of Magar population than other VDCs. In the study area, the Magars have 4243 households of the Magars.

5.3 Socio-Cultural Background of Magars and Health

In this section, socio-cultural backgrounds of the study area; such as social institution and social relationships, life cycle rituals, feast and festivals, deities and worships, folk song and dances of the Magars are described. The socio-cultural context of the people or community tends to have a great role in the construction of perceptions about ill-health and well beings, healings and health-seeking behaviours.

5.3.1 Social Institutions and Social Relationship among the Magars

Social institutions and social relationships are important to health and illness, health care and humanity in the community. The members of social institutions, kinships or social relationships could help to seek healings or rescue for the ill-person; in severe conditions,

accidents or emergencies and brought to the hospitals for treatments. Social institutions consist of all the structural components of a society through which the main concerns and activities are organized, and social needs (such as those for order, belief, and reproduction) are met (Marshall, 2007, pp.317-8). In another meaning, social institutions are the frames within which humans spend every living moment which is created and composed of groups of roles, or expected behaviours. The social function of the social institutions is executed through the fulfilment of roles. Social institutions provided basic biological requirements for reproduction and care of the young through the institution of marriage and family, kinship, etc., social security and other social needs.

Social relationship is usually a relationship between an individual and an entity (social institutions), but in some cases, it can be between two individuals or a relationship between two or more individuals or groups. The term “social relationship” will be used to denote the behavior of a plurality of actors insofar as, in its meaningful content, the action of each takes account of that of the others and is oriented in these terms. The social relationship thus consists entirely and exclusively in the existence of a probability that there will be a meaningful course of social action –irrespective, for the time being, of the basis for this probability (Weber, 1978, pp. 26-27). The social relation is related to the social action about social institutions and society. Here, family and kinship, traditional/customary institutions, modern organizations of the Magars are discussed based on the key informants’ information, FGDs and observations which are essential to health, illness and healing

(a) Family and Kinship

Family and kinship is an informal but strong social institution which creates the society. Kinship and family connections have an important role in society in bearing on matters of life and death. Kinship and family ties could be through genetic relationships, adoption, or other ritualized behaviours such as marriage and household economies. Kinship is a cultural system which recognizes family roles and relationships, and further defines the obligations, rights, and boundaries of interaction among the members of a self-recognizing group. In society, varying cultural attitudes toward marriages; kinship and family norms is culturally and socially constructed, for example, in some cultures, cross-cousin marriage is considered as desirable but prohibited as incest by other cultural group or society.

Among the Magars, there are sub-tribes such as Thapa, Rana, Ale, Ghartimagar, Budha, Roka and Pun where each is divided into many large numbers of clans whose members are widely scattered in the different geographical area. Magar society is patriarchal. However, females

have more freedom and rights than some of the other caste groups of Nepal. "Member of the same clan believes they all are descended in the male line from a shared (but now unknown) male ancestor; clan ancestors, it is felt, are related through male links to some extremely remote progenitor of the whole Magar tribe" (Hitchcock, 1966, p.59). Furthermore, "Magars who belong to the same clan cannot marry; otherwise, any Magar can marry any other, including members of his own sub-tribe. Regulation of Marriage is the major function of clans, and beyond this, clan membership is slight significance" (Hitchcock, 1966, p.59). This types of marries system and regulations of clans have dictated formation of family and kinship among the Magars.

Similarly, Oppitz (1983) has explored the marital systems of the Magar of the Rukum with their myth of origin. The researcher has found the patriarchal-clans (rus/rhus or bone) considered as eternal blood brotherhood and intra-clan marriage is prohibited which means if someone did intra-clan marriage is breaking rus/rhus or bone (clan) and this feature displaying clearly a marked rule of exogamy (p.226) marriage among the Magars in formation of family and kinship. In addition, the researcher has discussed one-way direction circular marriage system in between Pun, Budha and Gharti clans with maternal cross-sousing marriage. In this kinds of marital and kinship system, Shris (2073 BS) has also mentioned on the Baglung and Gulmi districts where he has found similarities with Oppitz (1983) and he has described Pun-Gharti-Shris clan's marital and kinship system in a one-way circular system of maternal cross-cousin marriage and kinships (Shris, 2073 BS pp.94-97). But in the survey, in the study area, such types of clearly distinct one-way directive circular system of maternal cross-cousin marriage and kinship in three or four clans are not found. The majority of the key respondents were unknown about this type of one-way directive circular system of marriage; however, the older key informants told that before in 3/4 generations, it existed when few clans (3 or 4 clans) were living in the village. There were no roads like of today and people had to walk a far distance to reach from one to another village. The key informants and participants of FGDs were agreed on intra-clan marriage and father's sister (*kutumba* family)'s daughter (*bhanji*) marriages are strictly prohibited. But maternal uncle's daughter marriage is customarily accepted. The kinship system among the Magars also differs with other caste/ethnics of Nepal such as *Māmā* denotes father of wife and brothers of the mother both, *Gumāji* (māiju) denotes mother of wife and wife of mother's brother both, *Nibā* (pusāi) denotes father of husband and husband of father's sister both, *Jethu* denotes wife's elder brother and elder sons of mother's brother both, *Sālā* denotes wife's

younger brother and younger sons of mother's brother both and so on (based on key informant and FGD's information).

The role of family and kinship in the Magar society have importance in the life cycle rituals, construct their own social institutions (e.g. *Bhejā*, *Pathebhāi*), worships for well beings; and co-operative works such as the construction of house building, public works, health care in the village or household level and support each other when someone falls into ill. Every life cycle ritual *kutumba* (husbands of sisters or daughters) and sister or daughter's presence and their assistance is needed in the Magar family to complete the life cycle rituals. In ill-health and medication, the family and kinships provide care to ill-persons, help to healings, bring into a shaman, an astrologer, a priest (traditional healers) and modern health care institutions (based on the conversation with key informants).

(b) Traditional Institutions/ Customary Institutions

The traditional institutions among the Magars, most of them were found disappeared, however, some residue of the traditional institutions is found in the current society. The key informants told that *Bhejā*, *Lānghā*, *Horakyā* (*horatyā*), *Pāthebhāi*, *Rodi*, *Ghānto bhailo*, *Sorathi/Maruni bhailo* were the heir traditional institutions among the study area and today most of them are disappeared and low in practice. And here, these are described based on information of key informants and focus group discussion.

Bhejā: The scholars BaralMagar (2050BS), Dhakal (1996) had illustrated the traditional institutions "Bhejā" among the Magars. According to them, Bhejā was an organization of a territory or several villages (in some cases) and Bhejā did a selection of village chief (Mukhiya) and Umarā, Pujaris (priest of forts/ shrine) within in gathering of villagers and fulfil the community needs. The bhejā also gave the justice and mechanism for mediating community dispute, the decision of infrastructure development, fixes the labour wage and prices of corns or goods, arrange common management (e.g. forest resource management), co-operatives of local development in a sustainable way. Bhejā also conducted the worships (pujā) such as Chandi, ancestral gods (*bājibajai/lhumpeki*), *sansāri māi* and several local god and goddess. In addition, Magar *Bhejā* "may allow even the non-Magars to become members, including the untouchable households of the same and a neighbouring cluster" (Dhakal, 1996 p.41) in the society. But this customary/traditional institution is near to disappear due to the development of political situation and bureaucracy, development of education and media, development and infrastructure without adopting indigenous cultural and linguistic safeguards in all development. The word "Bhejā" could be derived from the Magar language

"Bhe" equivalent to Bhayā means brotherhood and "Jā" means offspring which gives a meaning of the institution of clan or territory's where brotherhood could be established (Sinjali, 2071 BS pp 26-27). In the survey, the majority of functions described from BaralMagar (2050BS) and Dhakal (1996) had been disappeared but some residue was found only conducting some worship such as Chandi Pujā and other local worships in of local shrines for prevention or cure of illness and misfortune. They also help in carrying ill-person to a hospital or seeking healings also conducted from Bhejā institutions.

Lānghā: In Magar language *Lānghā*, the meaning is village or residents of a territory. *Lānghā* is not a formal social institution such as Bhejā and informal. But according to key informants, habituating *Lānghā* or *Lānghāli* ('li' suffix from the Nepali language in *Lānghā*) had good co-operation and they had helped to construct buildings for a living, maintenance, roofing through thatch, community works in free of cost in the before the one or two decades ago. They also gathered in life cycle rituals, helped in illness and seeking for healings. Habitants of the *Lānghā* had sentiments of "we" and co-operation but today such a system is going to degrade due to changing of the political system.

Horakyā/ Horatyā: This informal institution is formed to exchange labours with each other. It supplied labour forces do agriculture works. Baralmagar (2050BS) also described this institution. Generally, in this system, at least one person from one household comes and makes groups more members up to 15/20 (actually no limit) and work turn by turn in the field. *Horakyā* system could help to share their sentiments, emotions, troubles, problems with each other and they sing songs, take snacks (*arni*) together in the field which gives happiness, co-operative with each other and sharing. It helps to good health and prosperity. This co-operative of working system is degrading in the Magar villages due to migration, low interest in agriculture; youth are not available in the villages.

Pāthebhāi: This organization is based on husbandry of pig for rituals, feast and festivals, worships and ceremonies held within co-operative members of *Pāthebhāi*. In actual *Pāthā* denotes the male pig and *bhāi* means brother and it is an organization of co-operative groups who are keeping pigs at home. They share pig meat within the co-operative groups in feast and festival, ceremonies and life cycle rituals. The price of meat is also cheaper within the *Pāthebhāi* co-operative members than outside or market and sometimes bartering also occur. Within the co-operative members, somebody has not a pig in his home to fulfil the rituals or ceremonies; he will get from the co-operative members. In butchering a pig, the owner should distribute meat among co-operative members first; and the only surplus can be given to

others. In *pāthebhāi*, rice, vegetables, beans, bear/ raksi and other goods were collected from all members to help the affected household in death ritual and somewhere marriage or worship too. In some villages the one pāthi rice collected in the death ritual, therefore, it was said *pāthebhāi*. This system helps to keep co-operation with each other, provide nutrition for health and make a sentiment of 'we' in the community. However, these kinds of co-operative organization is in degradation due to open market, young generation migration for better job and life, changing social norm and values in the country.

Rodi: Rodi is a kind of youth club in a village. This traditional institution was for teaching and practice of cultures, kinship, folk song and dances; create and develop lyrics and music, share experiences and indigenous knowledge and skills, development co-operative sentiments, recognize and understand each other, love for marriage and develop kinship. In *Rodi Im* guardianship was provided from the village chief; or senior couples of the villages. In *Rodi* youth guests or experts from neighbour villages were invited. It is an ancient civilization of Magarat. *Rodi* (Gurung claims Rodhi) in etymological meaning *roha/ro* means love or kindness, mercy, sympathy, *dinke* means to get, which gives the meaning of getting love or kindness or sympathy in the club. Three decades ago, there were *Rodi Im* (Rodi house) in every village. Most of the villages have common buildings for rodi. Those villages have not constructed buildings, but they select one personal house for *Rodi Im*. It was widely accepted in the Magarat. But, in the late Panchyat ruling regime and restoration of the democracy, the national education system sprung in the Magar land then the teachers, literate or educated persons gave their opinions against the Rodi institution and culture. They also argued that this culture is hampering the student's study. Then the Magar students and guardian felt delusion about the Rodi. So, the Magars destroyed this institution themselves instead of improving the disfigurement or mutilations, and develop in the right tract. In fact, this Rodi institution system gave mental sympathy and love, cultural prosperity, happiness, co-operative, moral education, sharing indigenous knowledge and skills which became beneficial to good health and well-being. However, today such organizations could not be found in the study area, but some residue is found as sometimes dancing and singing in the name of the Rodi (based on the conversation with key informants).

Ghāntu Bhailo: This organization was for the conduct of traditional *Ghāntu* performance which is a lyrical drama, and culturally faith healings for the ill-person or family members. This drama is a tragedy based on god story and the name of Ghāntu is derived from the word *ghot* (*Ghewā* in Gurung/Tāmāng language) which means giving condolence or condolence

ritual. The Ghāntu bhailo, the household who are taking part in a performance, people who keep sympathy in folk dance collects the goods and money to conduct the Ghāntu and run performance in the village. In the study area, *Ghāntu* dance is performed for healing, good health and preventing misfortune (based on the conversation with key informants).

Sorathi/Māruni Bhailo: The *sorathi/māruni* dance is performed in the Magarat area by the Magars and including other ethnic groups. This is a lyrical drama and the Magars call it *Karhāng nāch* or *Pāngdure nāch* in the villages too. The *sorathi/mārunibhailo* is an informal organization to conduct sorathi dance. The hosting household, other public provides some goods, money (*Bhailo sotke*) to the dance performers, their directors, singer, drum (*mādal*) players and actors and do recreation. The sorathi/māruni lyrical dance is functioning through this institution. In contrast, today this customary institution is becoming weak in the Magar society; so Magars are going to loose their folk lyrical drama dance (based on the conversation with key informants).

(c) Modern Institutions

The main modern institution of the Magars is Nepal Magar Associations (NMA) which is registered according to Nepalese legislation. The NMA has sister wings like Magar Women's Association, Magar Students' Association, Magar Youth Association, Magar Ex-army and Police Association, Magar Cultural Association and other trade associations. The NMA has branches in every zone, district and abroad. In some districts, VDC/ Municipality level branches are established and somewhere in a basic level of ward or Magar village level. In the study area, all VDCs have Nepal Magar Association branches but in the latent situation. The NMA has their-own building in Galyang Bazaar of Jagatradevi VDC. The Magars of the study area celebrate the anniversary of NMA (on 15 Phalgun) every year, but the celebration is seen high in an urban area. Generally, the celebration is organized as a picnic, dancing program and singing program but no academic seminars, literary programs and exhibitions of traditional heritages, indigenous knowledge and skills.

Though Magar Association (NMA) is an umbrella organization of all Magars, they are weak in uniting Magars, lobbying in genuine issues, conservation and develop ancestral mother tongue and culture, advocacy of multi-lingual and multi-cultural issues, literary works and research works, capacity buildings in grass-root level. In addition, Nepal Magar Association (NMA) expanded on a big mass of the Magars and scatter all over the county as well as abroad. Due to high population of the Magars, they have large-scale voters, so the political parties interfere or lobbying in the selection of leaders in their general assembly. So that,

Magar voters can be attracted towards their parties, secure party's vote, and influence issues regarding indigenous issues. The political parties or ideology have easy to enter Magar settlement through in name of NMA. Beside this; the elected NMA leaders are loyal to their own parties or party's leaders rather than the issues of the Magars. They are also not doing inclusion within the organization. Therefore, the problems of Magars and ethnic groups always remain the same at public level².

The function of the NMA regarding health and illness is the collection of funds to help individuals who were falling into a severe illness. They also organize charity programs to help ill-person within the country and abroad, organize blood donation programs. In the village level, there was not any significant presence of NMA in ill-health and health care support. The family, kinship, villagers and well-wishers support in illness and misfortune. Furthermore, there are several organizations registered as per Nepalese Legal provision from the Magars (based on the conversation with key informants).

5.3.2 Life Cycle Rituals and Health

The life cycle rituals occur in every culture and society. The life cycle rituals provide the provisions of family, kinship, social relationships, and cultural tie-up, neighbourhood, humanity and willingness of good health to function the society. The life cycle rituals are the basic things in the construction and functioning of the society, cultural practices and ethical issues to the human life and for social norms and values. Society and culture of the particular area or nation construct the boundary and practice of the life cycle rituals to conduct the social function according to their natural and social environments. However, constructed and having long practiced, amended according to time and situation, and improvised according to the natural and social environments life cycles gives continuity and dynamics of society and culture. Being the long practiced, constructed from the society according to environment or ecosystem; in life cycle rituals, there has been the existence of perception of ill-health and medication or good health. Here, such perception of ill-health, medication practice or seeking good health on life cycle rituals among the Magars is discussed based on the conversation with key informants of the study area, focus group discussions.

(a) Birth and Childhood Rituals

The Birth, Chhaiti, Naming ceremony, weaning (*bhātkhuwai*) ceremony, Chhewār, *Gunyucholo yahake* are the birth and childhood rituals among the Magars of the study area.

² Observation of 11th General Assembly of Nepal Magar Association (NMA) which was held in Chitwan on 18-22 Baisakh, 2073 BS (where Nabin Roka Magar (Rolpa) was elected as president of NMA) and their activities.

The birth and child rituals among the Magars are discussed here based on the conversation with the key informants.

(i) Pregnancy and Birth

The pregnancy and gestation period is considered as pollution for worship, sacrifice or hunting for both males and females among the Magars of the study area. The husband of the pregnant women could not do the role of *Umarā* or *Pujari* among the fort, or shrines and even in their ancestral worships, *kulpuja*, etc. In pregnancy, it is believed that if the husband killed the animal or birds, the pregnant women's health could have worsen health condition, face difficulty in birth-giving, mother and child ill and child shows the animal character after birth, then illness may occur frequently. There has been a practice of prohibiting lifting heavy load in pregnancy too and after giving birth to a child for few months which is beneficial to prevent stillbirth, uterus prolapsed and other maternal-child illness. Some foods are prohibited in pregnancy for special causes. In local illness *moch* or *mos* (frequent abortion or child death after birth), they prohibit eat bananas.

In giving childbirth, there were local senior females as childbirth attendance (like Sudeni) to help the mother. After childbirth, the cord was cut by the *hunk choyān* (bamboo cane splinter) and tied with thread in the past but this practice disappeared with introducing modern health care in the villages. Then bathing for children with warm water was also practice in the villages though today such traditional practices have been changed due to the development and availability of modern health care. After the birth of the child, parents and all *bhāikhalak* falls into pollution for worship deities and shrines until *naurān*. The families and relatives give to drink fresh blood of chicken (especially cock), a goat for mother because the Magars have a belief that the fresh blood of rooster, goat, sheep could replace the blood discharge in giving childbirth process. Similarly, soups of chicken, or meat, soup of *juwāno* is also given to mother enrich the nutrition. The Magars consume *pork* and somewhere *buffalo meat* but they do not give to consume for mother in *sutkeri* period. There was also weakness in providing green leafy vegetables for mothers and they have a belief that such vegetables could make cold for mother and a newly born child. Furthermore, the bed of the mother and newborn baby has a near hearth or oven where the fire was burned to cook, believing to warm the mother and newborn baby (based on the conversation with key informants).

Some parents do the *chhaiti* ceremony, inviting the relatives and villagers on the sixth day of childbirth. They arrange a feast, folk dances or songs for recreation and celebrate happiness. This custom is not essential and optional in Magar villages. According to Brahmin

mythology, in the sixth day, the *bhāwi* (god of writing fortune) comes to write the fortune of newborn baby and Magars also believe in this mythology in villages, therefore in that day celebrating happiness, the *bhāwi* god will write good and lucky fortune of a newborn baby and prevent from the illness and misfortune (based on the conversation with key informants)

(ii) Naming Ceremony (Naurān)

Among the Magars, *Naurān* (naming ceremony) has been done on the 11th day of birth in general but if there come some circumstances can be done on 3rd day or odd days according to their convenience. If there are some festivals or worshiping program of deities or ancestors in *bhāikhalak* households, then *Naurān* (naming ceremony) day can be reduced for their convenience because *bhāikhalak* fall into ritual pollution until *Naurān* (naming ceremony). In *Naurān* (naming ceremony) *kutumba* went to Brahmin priest or astrologer (or *wārch bharmi*) for matching name or a first letter according to calendar and Hindu philosophy, and enchant by mantras to *Gaunt* (urine of cow) or *Gerdi* (water where gold dipped). Then *kutumba* comes and prepare *mhegrit* (fire charcoal) for worship and give *dhup*, burnt fire and keeps *bhalāyo* (a kind of plat which has allergic properties), *siru* (a kind of thorny grass), *kurilo* thorn and other thorny and poisonous plants on burning fire, then fumes come near where the baby has kept. It has a belief that the fuming of allergic and poisonous plants helps to vaccinate the child and those plants do not cause allergies and poisonous in the future and helps for good health.

The *kutumba* gives *dhup* in *mhegrit* and tells the name of baby and parents (*myārmin nghoske*) and gives the thread enchant through mantra by the priest (*pandit*) to baby and parents. Then he sprinkles *gaunt* or *gerdi* to parents, household members, a garden of fruits or vegetables and all *bhāikhal* households for purification from the *sutak*. Then *kutumba*, parents and invited relatives take feast. Some of the wealthy people organized a big feast on the occasion of *Naurān* (naming ceremony) becoming the parents of their first baby son.

(iii) Weaning Ceremony (Chho Kāske)

In Magar culture, the weaning ceremony (*Chho Kāske*) is done in the 6th month from the birth for a male baby and the 5th month for a female baby. Until the weaning ceremony; the solid foods such as *chho* (rice), *beskām* (bread), *met* (curry, vegetable), etc are not given to the child. There is a belief that if such solid food is given a newborn baby before the weaning ceremony, the child's health could be degraded and sometimes child could have a slightly mental retardation/illness like *Loshe*, *Londe* and *khanchuwā* (overeating). The child who was

missed to the custom of weaning ceremony could be slow, overeater, and having misfortune in his/her life.

In weaning ceremony or feeding ceremony for baby, the *swādhyā or sehech sāita yāk* (auspicious moment day) and in some places first feeder person or *kanya* (virgin girl) is selected with the help of *wārch bharmi, lāmā* or Brahmin priest and fix the date. In weaning ceremony, generally, a feast is organized inviting intimate or near relatives. Wealthy persons or happy in getting son, they organize big feast inviting all villagers and kinships; and further they also organize *mārūni/sorathi* lyrical dramatic dance, *rodi* and other folk dance and songs for recreation. The varieties of food (ideal thirteen varieties or odd) including rice are prepared to feed the baby and an odd number of *kanyā* (virgin girls), at first, feed to the baby at the auspicious moment and then parents and relatives feed the child turn by turn. In such feeding ceremony, the baby should have to cry. If he/she does not cry, there is a belief that s/he will be the victim of illness and misfortune; therefore, someone pinches the baby to make him/her cry. Generally, in the weaning ceremony, the Magars give meat of chicken, but not pork and other meat items. BaralMagar (2050) found that a belief of feeding a bird's meat named *bhadrai* (a kind of bird) believing the child will be clever and healthy. And in the study area, older key informants shared the beliefs as mentioned by BaralMagar (2050 BS) but the younger generation was forgetting this belief related to health and cognition of children. Before feeding the baby and serving food guests, they worship their ancestral gods or deities and offering the foods for good health and prosperity (based on the conversation with key informants).

(iv) Chhewār

Chhewār custom is considered as the first hair cutting from the maternal uncle of his sister's son. In this custom, generally maternal uncle comes in to the sister's house. The parents arrange a small feast inviting intimate or near relatives. The parents prepare the son to get his hair cut. Then maternal uncle cuts the hair of his *bhānja* and he gives gifts including a Nepali cap (*DhakaTopi*). Until the *chhewār* ceremony, generally, hair is not cut, and after celebrating *chhewār*, cutting the hair of the son is free. This ceremony is done after five years or later but in the odd years of child's age. Before three/four decades, there had been a social norm that the marriage was not held without doing *chhewār*. If someone was not completed *chhewār* ceremony, he should be completed it before going to the bride's parent's home for *dhogbhet*. But nowadays, this custom is going to disappear due to the influence of other cultures, and migration for job-seeking from the villages, maternal uncle being away due to

job or business. However, this custom also teaches a child about the growing age, male responsibilities, household and family education, health and illness, other social norms and values (based on the conversation with key informants).

(v) **Gunyucholā Yāhāke**

Gunyucholā yāhāke custom among the Magars is having purpose to teach the daughter about growing age and becoming adolescence age and future adult. After doing the ritual of *Gunyucholā yāhāke*, in the past, *the* daughter is considered as marriageable age. In the study area, the Magars do *Gunyucholā yāhāke* at the age of 7 to 13 years old or more, but an odd age. In this ritual, parents invite intimate kin or relatives and arrange a small feast. Then they give the gift of *gunyu cholo* or *ghānghar* to their daughter. If someone has not completed *Gunyucholā yāhāke* ritual, then parents can give a gift of *gunyu cholo* or *ghānghar* to their daughter on *Dhobhet* custom of the marriage. However, this custom is going to disappear in the study area because most of the girls wear such types of dresses in their early childhood. So there is not different dress in childhood and adolescence in society. Furthermore, this custom is not in the mainstream culture of Nepal, so the education system and media do not give priority to describe importance and history of this custom. By this, Magars are influenced by the national education system and media, so they forgot this culture. Therefore, they became unable to show interest in the development of custom and make it compatible with changing society. Nowadays, rarely this *Gunyucholā yāhāke* ritual is seen in the study area. This culture was helpful to understand the age, body changes for health and other household education to daughter (based on the conversation with key informants).

(b) **Marriage**

Marriage is the union of the male and female which creates the family and society. The responsibility of sexual relationship, reproduction and care of children is created through the marriage system in the society. Marriage helps to accelerate the human gene socially and culturally to the future of the earth. Among the Magars, maternal cross-cousin (*māmā cheli-phupu chelā*) marriage is practiced. However, they prohibit marriage between the daughter of sister (*bhānji*) and son of brothers (*māmā chelā-phupu cheiā*)'s cross-cousin. In general, most of Magar male and female youths meet before marriage and they come to know each other; fall into love, and then elope to marriage. However, among the Magars, arrange marriage, love and elopement marriage (Gandharva Bibah), marriage by pulling (*tāni bibāh*), widow marriage, jari marriage are in practice (Baralmagar, 2050). Nowadays, jari marriage and marriage by pulling (*tāni bibāh*) are not in practice. Widow marriage and widow marriage by

her husband's younger brother is decreasing due to the influence of Hinduism or Brahmin Culture. In the marriage by pulling (or forceful marriage), there was a system to return girl in her parent's house; and the male side parents had to be punished if the girl was not agreed with that marriage. Returning to her parents, she was considered a virgin and could marry others. In Magar society, a female could easily leave her husband if a dispute arises and can marry others. In contrast, this trend is changing due to the influence of Indian Hindu philosophy and media.

In the Marriage ritual, Magars do mainly *Jhorkedupke/Dogbhet* and *Tikā* in both bridegroom and bride house including a feast. Generally, the bride goes to the bridegroom's house falling in love and elopement, then on appropriate or auspicious moment and day, the parents and relatives of the bridegroom get gathered. They give *Tikā* and bless them, then couple greets their parents and relatives according to kinship relations and enters into parent's house. In arrange marriage, the majority of Magar parents send their daughter with the bridegroom at a suitable time to do recent *Jhorkedupke/Dogbhet*. Some parents, who have fallen under extreme influence of Hindu culture and try to follow Brahmin culture, arrange marriage like Brahmins. The Magars who are wealthy and served in Nepalese bureaucracy or educated peoples from the national education want to show supremacy in the society. So they are kin to follow the Brahmin culture in marriage rituals, lay Magar's follow the ancestral marriage custom.

After accepting the bridegroom's parents, they inform to bride's parents through *kutumba*. Then they arrange the *Jhorkedupke/Dogbhet phoke* ceremony in the bride's parent's house at their appropriate time. Therefore, sometimes it takes a few to more years to arrange *Jhorkedupke/Dogbhet* ceremony on the side of the bride's parents. For this ceremony, *Kutumb* goes to the bridegroom parent's house to ask and arrange the *Jhorkedupke/Dogbhet phoke* ceremony with yoghurt *theki*, *sagun* and gifts; which is called *ginhke/sodheni*. In the *ginhke/sodheni* custom, they decided to date of *Jhorkedupke/Dogbhet phoke* ceremony and fixed the *pāhur* (gifts) from the bridegroom side to the girl's parents. In past, there was a custom of demanding pork meat or goat, chicken, *bārā*, *sel*, *raksi* (liquor), etc. and sometimes even rice form the bridegroom's side to girls parents as gifts for the ceremony; but nowadays such system is reduced and increasing dowry system and demanding more *janti* due to influence of Brahmin and Indian culture.

In *Jhorkedupke/Dogbhet* custom, the groom goes to the bride parent's home with *Janti* and *pāhur* (gifts) leading by the *Kutumba*. The girl's parent and relatives sprinkle with the water,

flowers or *pātisār* and *achhetā*, then they give *tikā* for bridegroom and bride and do greeting custom, groom and bride greets according to kinship relationships. In past, there was custom sacrificing hen and cock at the same time and kept one place. This was done to determine the fortune according to the movement of the slaughtered hen and cock. For example, if the hen's leg kicks the cock, the bride will be superior or dominant to the groom whereas if the hen dies earlier, the bride will die earlier than the groom. If both stay together, the married life will last long or separation could be a divorce, etc. They also estimate future health, number of children and their health, etc. but nowadays it is not practiced because the expert *lāmā* (shaman) or *wārcha bharmi* are not available in the villages. Similarly, there is a belief of misfortune and unhealthy in future if yoghurt *theki*, *sagun matiyā* (small mud pot with *hān*) or *pāhur* is damaged or spilled on the way. After greeting ceremony is over, the groom and brides, *kutumba*, *lokanta lokanti* and relatives take food in the feast. In the returning time, again parents and relatives give *tikā* for groom and bride and then offer a farewell.

In the groom's house, they organize a feast and all relatives are invited. After returning from the bride's parent's home, they also sprinkle with *acchetā*, water and flowers and give *tikā* to the groom and bride and start greeting relatives (*Dhogbhet*) according to kinship relations and enter the house. On the 3rd day, again, the bride and groom with *kutumba* go to the bride's parent's home (Māmāu Im) and this custom is called *durgān lhetke*. On the night, they stay there and returned to the groom's home the next day. The new kinship after marriage is *Māmā*, *Moiju* and *Bhānja* for the bride's parents and grooms accordingly.

Cross-cousin marriage practices among the Magars were more in the past and nowadays such practices are going to be reduced, however, cross-cousin marriage is still in practice. The majority of Magar couples have already known each other, their health, habits before marriage or elopement due to near and dear kinships and long contact with each other. However, there is a practice of arranged marriage among the Magars in the study area (based on the conversation with key informants).

(c) Death Ritual

Death is a sorrowful but inevitable event of human life. Every organism is born, does reproduction, and at last, dies which is a natural phenomenon. It is also implied in the life cycle of human too. Human beings are intellectual and social organisms; therefore, they have a practice of death ritual in the society though there might be different practices and concepts in death rituals according to their society, culture and living environment. The death ritual gives information about the cause of death or illness, dead person, and share condolences to

the dead person. The kinships and society give farewell to the dead person from the society. The Magars are indigenous peoples of Nepal, especially in the ancient Magarat territory, they have distinct cultures and perceptions towards understanding the socio-cultural events. In Magars, they take sorrowful and inevitable events to death rituals. The deceased soul goes to settle in *Boikungthau* or heaven (the imaginary place where dead ancestors lived). Those departed souls which are not able to go to the ancestral living place (heaven), wander around and give troubles to the living being including humans causing illness. Similarly, the souls which are living in *Boikungthau* (the imaginary ancestor living place), give powers to living people to become healthy, prosper and happy. Therefore, they remember the departed souls and do worships to ancestors in various forms of deities or gods and goddesses.

In Magar villages, when somebody dies, the deceased body is considered impure and *Bhāikhalak* (brotherhood) the families are also considered impure and do not take part in worships until the purification ritual is complete. The Magars are having a practice of both burying and burning to the corpse, but they do not burn to dead shamans. Before the corpse is moved to the cremation process, they protect the deceased body from the touches of the birds and animals. In the death ritual, the *kutumba* (father's sister's husband or sister's husband or decedents) have a major role to complete the death ritual process. The Magars do not play *Shankha* (conch shell) in the process of carrying the corpses to cremation, but they make a lam (way) of the flag of white cloths and caught from the *kutumba* and corpse from the *Bhāikhalak* until the cremation. In the death ritual, when they move the corpse from the house, they smear (*lipnu*) the house in direction to outward from inside, believing cleaning the house and all illness or soul throwing outside from the house.

After cremation of the corpse, they burn the fire adding ghee or oil. All the mourners who have gone for the cremation of the corpse, take flame of fire (*mhen lhapko*) with the palms of their hands or round moving cap at *Ghāt* or *Chihān* (cremation place) which is called *mhe dhup lāke*. Finally, they return home. While returning home, on the way, few distances from the *Ghāt* or *Chihān* (cremation place), they keep a thorn plant and all mourners do *ju thāpke* (touching by foot or footing to thorny plant) and return home. This is done due to the belief that the souls of the *Ghāt* or *Chihān* (cremation place) can not follow the mourners (*malāmi*). Because the souls of *Ghāt* or *Chihān* (cremation place), and dead person's soul could cause illness for human being and animals at home. It is also better to take a bath at home or tap or water source before entering into the home. But *kriyāpatri* do not do this *mhe dhup lake* and *ju phetke*, and they farewell to dead person's soul on the *ghot* day (condolence feast day).

The Magars mourn generally for ten to thirteen days as other Hindus, but in Galyang Bazaar of the Jagatradevei VDC, they mourn for only seven days. On the cremation day, the son of the deceased person or *Kriyapatri* does scalpel bald on the head from the *kutumba* and bald axilla (underarm) and groins hairs then take a bath in Gandaki River. The wives or females, who do not go to the river, bath on local water sources or natural taps. In the evening, the *kutumba* gives unripe bananas frying to *Kriyapatri*. The next day, all *kriyapatris* go to a nearby stream and water sources. The *kutumba* provides all cooking materials, but they cook food themselves and eat after taking a bath every day, until the *ghot* (condolence) feast is over. They do not eat salt and meats and are allowed to eat food once a day. However, they can eat fruits in the period of *Kriyapatri*. The *Bhāikhal* also do not take salt and meat till *ghot* (condolence) feast is over. The *Kriyapatris* are considered impure and are not allowed to do household works, and abstain from the touch by other people and animals or birds or chickens. And, those females who do *thado kriya* can do household works but need to take a bath every day. The kinships from the sister bring a gift of ghee and fruits to the *Kriyapatri*, and from the brother's side, they have *pāthebhāi* system in the villages which they help in *ghot*.

On the third day, a chicken is sacrificed and offerings to the soul of the deceased and ancestors. Similarly, in *khola* (stream) or water source, *Kriyapatri* gives *muthi* (giving food for the soul of the deceased person and ancestors) to please the ancestor's soul for good health, prosperity and good fortune. On the tenth day or *Dasgatra* day, all *bhāikhalak* (patriarchal lineage) gather at a stream or water resource with *Kriyapatri* and discuss on their custom, amend if necessary, and work for the preparation of *ghot* (condolence) feast.

On the *ghot* (condolence) feast day, all villagers, relatives gather. The brothers who are not taking salt in mourning period, touch a *tapari* (leaf plate) with *salt*, *chicken leg (meat)*, *gherenā* (a medicinal plant), *titepāti* (medicinal plant), *ghyo* (nettle), *bomosyā* (*kubhindo* in *Nepali*), *hān* (bear made from corn), *gau mighyā* (chicken thigh/leg: if the dead person is a female, it is kept on the left, and if he is a male, it is kept on the right), ginger, garlic and water, etc. The number of items kept in that *tapari* (leaf plate) has to be odd and lit the lamp of oil or ghee keeping in *Dunā* (leaf cup) with *dhajā* (thread gathered). This custom is called *chhā chhuke* (touch salt). This shows the devotion towards ancestral souls, if the lamp puts off in someone's touching to the *tapari* for *chhā chhuke* custom, it is considered that the person was not devoted to abstaining salt during the period of mourning. In this custom,

devotion to ancestor soul abstaining salt and meat, ancestral souls bless to him and families to good health, good fortune and prosperity.

In the evening of the *ghot* (condolence) feast day, there is *unggyā bhākke* custom. In this custom, one chicken is sacrificed (cock for male, hen for female) and other things are also cooked to offer to the departed soul or ancestors. The *kutumba* asks all the *bhāikhal* to sit inside the door and start *unggyā bhākke* custom. The *kutumba* keeps the *tapari* (leaf plate), *mhegrit* (fire charcoal) for offering *dhup*, offering foods, fruits also and lit the mustard oil lamp (Batti) of *dunā* (leaf cup) in the *Galām Sangghār* (door). Then one chicken is sacrificed (cock for male, hen for female) in the *Galām Sangghār* (door), *dhup kāke* is done. One leg and head of chicken are kept outside the door and other remaining parts are given to *bhāikhal*. Similarly, the offered foods, fruits, etc are divided into two shares where one share is kept outside the door and one share is given for *bhāikhal*. If there is the presence of *lāmā* (shaman) or *wārcha bharmi*, or old persons, he tells the stories and Magar philosophies about life and the end of life. The *kutumba* offers the *pujā* and *dhup*; *pātisār*, flowers. At the same time, he takes one leaf and he pulls this leaf from inside the door to outside saying *Ungyā or Minggyā bahiring kheuna, pitrikothung āna, kānke dukh nāheu* (Oh! soul go out from the house and stay into the heaven, give us power but not troubles). Then the all offering foods, *pātisār*, flowers and chicken parts which were kept outside the door are gathered in the *tapari* (leaf plate) and brought out in the compound of the house and kept in *chokyā lām/Dobāto* (crossroad, a juncture of two or more roads or paths). The sacrificed chicken *bhāikhalak* is cooked or barbequed. They eat all the offered foods, and they come out of the home only after finishing the food. In this ritual, they have a belief that the deceased soul could cause illness for human and animal, therefore, they should separate the soul from the *bhāikhalak* and the house. The soul of the dead person, if reached and stayed at *boikungthāu* or *Pitrilok* (heaven), provides protection and helps to good health and prosperity of the living members and animals.

Furthermore, some Magars follow the *Brahmin Pandit* (priests), however, they follow the basic Magar ritual culture and Brahmin culture together. Similarly, some Magars are following Buddhism developing *wāpā* (local priest), they are also following both Magar traditional and Buddhist cultures in the study area. The majority of wealthy Magar families follow the Hindu Brahmin *pandit* (priest) and provide valuable gifts, money, etc. to him. The families having low-income sources finish death rituals from the *kutumba*. Activists or due to influence activism, some families are adopting the *wāpā* (local Magar priest). However, they

have not left their ancestral custom in death rituals though there are some deviations in the villages (based on the conversation with the key informants).

5.3.3 Feast and Festivals

Feast and festivals of the ethnic groups or community provide social relationships, increase kinship connectivity, relax and entertainments and brings healthy environment among the family and community. BaralMagar (2050BS) has found that Sāune Sakrānti, Janai Purnima and Krishna Astami, Tij, Pitri Ausi, Badādashain, Tihar, Pandhra Push, Maghe Sakranti, Basanta Panchami, Yaunat, Chaite Dashain, Chandi as the Magars' festivals (Baral Magar, 2050BS, pp.118-124). In this section, feast and festivals among the Magars of the study area are discussed based on the key informants' information and observations of the field.

(i) Baisākhe Sakarāti

Baisākhe Sakarāti is Nepalese New Year's Day. On this day, the Magars take baths in streams or water resources of villages though some Magars go to take baths in *Kāli Gandaki River*. House smearing and sanitation are maintained. The Magars worship the ancestors and offering them sacrificing a chicken, cook *Bāra* (a kind of food made from beans or lentils). After taking a bath, they take honey if possible. Taking honey on this day is believed that prevents them from many kinds of illness on this holy day. They invite relatives and gather to feast. On this day, agriculture works have been done *nātle* (holiday). They also organize Rodi, Jhāmre, etc. folk dances and songs for entertainment. In contrast, nowadays, due to migration especially due to youth migration for hunting jobs and better education, the celebration pattern of *Baisākhe Sakarāti* is changed in the village and is not found entertaining as it used to be two/three decades ago (based on the conversation with key informants).

(ii) Chandi Purnimā

Chandi Purnimā is also known as Baisākhe Purnimā. The festival is celebrated doing Chandi Pujā. Chandi Pujā is generally done in Budhha Purnimā, but it is even conducted in Chaitra, the last month according to the Nepali calendar. In some Magar villages, it is celebrated in Purnimā (full moon) of Baisākh month. In *Ghānto* dancing area, the last episode of the *Ghānto* is organized in the *Chandi Purnimā* and performed for two to three days with closing ritual ceremony and feast. In this festival, the Magars invite the relatives for a feast and go to relative's houses being guests and take *prasād* (offering) of Chandi Pujā.

(iii) Dasaharā

Dasaharā festival is celebrated in *Ashār* month of the Nepali calendar. In this festival, there is a belief in taking ten varieties of vegetables and foods on that day. Taking ten varieties of vegetables from different plant sources and foods keeps them healthy in the monsoon season. Similarly, they catch the parrot, *sārau* (common mynah) birds to make pets in houses because if an early morning of Dasharā catches the birds, there is a high possibility of speaking of the birds and quality. Dasaharā was considered as the starting of monsoon in the Magar villages. In the earlier days, they used to invite guests from relatives and organize feast cooking ten varieties vegetables or curry and foods. But nowadays, celebrating *Dasaharā* festival has been reduced. Most of the Magars do not give the interest to celebrate this festival (based on the conversation with key informants).

(iv) Saune Sakarāti

Saune Sakarāti is celebrated on the first day of Sāun month of the Nepali calendar. On this day, in the morning, they bring leaf of *bhalāyo* (a plant which can cause allergy), *Kush*, *Siru*, *Sijhān* (cactus) and insert them into the roof of the house in front of the main door. In the evening, they throw the *mhegrit* (charcoal having burning fire) with shouting '*luto, rog byādhi patta ānha*' (all scabies, itching illness, illness and misfortune go out) and not make them ill'. They have a belief in throwing *mhegrit* and shouting, the causative agents of illness will be chased from their home and it will bring good health and prosperity in the house. In the evening, the youths gather, prepare *tiuri* (a kind of plant which gives henna color) and tie on the palm of a hand and open in the next day or a few hours later. This process gives a colour to the nail and hands. Similarly, there was a tradition of inviting relatives and arranging feasts and going to the relative's house. Nowadays, the celebrating pattern of *Saune Sakarāti* is changed. Many Magars are leaving to celebrate this festival and due to modern medicine (bio-medicine) concepts and public think that throwing *mhegrit* (cannon light or charcoal fire) custom is related to superstition and no role in curing skin illness or preventing illness. Similarly, the *tiuri buke* custom is replaced by the Indian *Mehandi* (henna) which is easily available in the market (based on the conversation with key informants).

(v) Janai Purnimā and Krishna Astami

The Janai Purnimā and Krishna Astami are not related to Magars. However, being neighbour of Brahmins, the Magars also celebrate these festivals. Generally, the Magars were not arranged to feast and did not do *nātle* (holiday) in farming works. Only the Brahmin priest comes and gives the thread with tie rounding in the wrist of hand and took *dakchhinā* (paying

money to the priest) in *Janai Purnimā*. In Krishna Astami, the Nachari (a lyrical dramatic dance) based on the God Krishna's life story (*Krishna charitra*) is performed in some Magar villages but in the study area, it has vanished. Nowadays, due to media and government emphasis for this festival, youth Magars are also entertaining with Brahmin customs and Newar's Jatras on the occasion of the festival (based on the conversation with key informants).

(vi) Teej

In *Teej* festival, Magars invite married sisters or daughters. The brother or someone goes into sister or daughter's home for an invitation and carries them together in parent's or brother's house (*chyālibyāti lāhānke*) on the day before *Teej*. That day is called *dar jyāke*. The parents or brother sacrifice a chicken worshipping or offering to their ancestral god goddess or other godlings. They cook rice adding some ghee (*khajā*), chicken, pork, vegetables and delicious foods for their sisters and daughters, and fed them fully. During *Teej*, if parents or brothers do not give an invitation for sisters or daughters, they become sad having thought of '*māiti* have forgotten them' and generally do not go for *Dashain Tikā* to parents' or brother's house. On the day of *Teej*, *chelibeti* take food and go to entertaining places where *Teej* songs and dances are arranged. A few decades ago, the Magars had their own dance and song called *jhorā*, which is completely disappeared in the study area due to the influence of modern media and social changes in the country. Some *chelibetis* who are influenced by the media's broadcasting and Brahmin culture, abstain foods in *Teej* and do worship in *Panchami* with a Brahmin priest and give him *dakchhinā*. But a majority of Magars do not follow the Brahmin culture in *Teej* festivals. On *Teej* occasion, *Rodi muke* program is arranged in the Magar villages for entertainment (based on the conversation with key informants).

(vii) Badā Dashain

Badā Dashain festival falls in September/October month. In *Jamare Ausi* (last day of the dark fortnight of a lunar month) Magars perform *muthi dāke* custom at stream or water sources for the soul of their dead parents and ancestors, therefore, it is also known as *Pitri Aunsi*. On this day, the Magars sacrifice chicken of offering to the soul of dead ancestors and they invite the *kutumba khalak* or sister/daughter's side relatives as guests and feed them. The Magars who follow Brahmin culture do *Shrādda* in *Sohra Srādda* period (or tithi) of Dashain festival calling priest and giving the *Dakchhinā*. But the majority of Magars celebrate *Pitri Aunsi* and after *Muthi Dāke* ritual, they give the *dakchhinā* for virgin girls, *kutumbas* and relatives from

the sister or daughter's side. On the following day of *Pitri Ausi*, they sow *jamarā* for *Dashain* in the houses.

Fort (kot) worship is also another important aspect of the *Dashain* festival. The fort is locally called kot; the word borrowed from the *Pharasi* language and in Magar language called *Jong*. In *Jong* (kot), traditional weapons are kept such as *Khukuri*, *Tarawal*, *Khonda*, traditional and local-made guns, bows and arrows and worshiped every *Badā* *Dahsain* and *Chaita* *Dashain*. In *Badā* *Dashain* festival, the following day of *Pitri Aunsi* *Jamarā* is kept in the kot (*Jong*). In *Sattami* (7th day), the Magars gather *atsār*, *pāti* and worship in local *Chandithān*, then bring to *Kot* (*jong*) with playing *Naumati Bājā* and keep inside (*sārapāti bhitraitke*). Therefore, it is called *Sārapāti* (*phulpāti*) day. The *Sārapāti* is ritually disposed into a stream or water resources doing worship on the 10th day of *Dashain* before *Tikā*. On *Astami* (8th day of *Dashain*), the Magars do *Pitripuja* (worship of ancestors) butchering pigs in the villages. In the evening, they go into *Kot* (*jong*) for *Kālarātri* *Jagadike*. On that day, they invite close relatives and feed them. In *Nawami* (9th day of the festival), they offer *Panchabali* (a sacrifice of five kinds of animals and birds or more than five in an odd number) in the kot with *Rāngā* (he-buffalo) from the *kot* (*jong*) management or villagers in common and individual households. The households, who have not *Panchabali*, take a chicken (cock) and *Achhetā* for worshipping in the *Kot* (*jong*). In the *kot* (or fort), there are two types of priests; *Umarās* and Brahmin *pandit*. The *Umarās* is a clan from Magars. The *Umarās* do sacrifices, maintenance and sanitation of the work of fort (*Kot/Jong*) gathering villagers. At the same time, the Brahmin priest reads the Mantras of Hindu holy books by chanting. There is a belief that if some defect occurs while offering and worshipping ritual in the fort (*Kot*), the *Devi*, the deity of the fort (*kot*) will send a tiger or leopard which kills household animals and sometimes man too. The deities of the fort (*kot*) could cause illness and misfortune; therefore, the peoples offer *Panchabali*, sacrifice chickens and give *Achhetā* to the *Kot*.

The *tikā* ceremony is performed in *Dasami* (the 10th day of festivals). The Magars use rice, yoghurt and *jamarā*, *titepāti* for *Dashain Tikā* festival. The *Dashain Tikā* is generally celebrated until *Purnimā* (full moon) day. However, in some of the Magars villages, *Tikā* is celebrated on the days of *Dasami* and *Purnimā* in recent years. Similarly, some Magars are leaving to perform *Tikā* of *Dashain* and celebrating *Dashain*. The media and government broadcast it as the Hindu festival and a festival celebrating the victory of good over evil. Furthermore, Christian Magars do not celebrate *Dashain* festival. The festival helps to gather family members and get together with relatives to socialize and renew the relationships

between kinships. But overeating meat, fatty foods and drinking could be harmful to health and sometimes cause illness during *Dashain* festival (based on the conversation with key informants).

(viii) Tihār

Tihār festival falls in October/November months. In Tihār, dogs are worshipped before Laxmi Puja at Tihāre Ausi. At *Tihāre Ausi*, the goddess of property called *laxmi pujā* is performed. On this day, the Magars worship pots, jewellery and valuable assets and properties with a garland putting on copper vessels or pots. On the next day, they worship cows and oxen with a garland and give them delicious food. On the day of *Bhāitikā* of Tihar, sisters put *Tikā* on their brothers' forehead. The *Tikā* is different than of the Dashain. The sisters feed their brothers with delicious food and give them gifts. In return, the brothers also give gifts and money to their sisters. During *Tihār*, from *TihāreAusi* to *Bhaitikā*, *Bhailo* folk songs and dances are performed. After *Bhaiika*, for 2-3 days, *Deusi* folk songs and dances are performed in the study area. In Tanahun and Palpa districts, *Deusi-bhailo* is performed until *Kāttike Thuli Ekādashi*, but in the study area, such custom is not found and it is finished in 2/3 days of *Bhāitikā* (based on the conversation with key informants).

(ix) Kāttike Thuli Ekādashi

In *Kāttike Thuli Ekādashi*, the peoples go to Kāligandaki river, particularly to Setibeni, An dhimohan, Ridi and *Rāmdif* for ritual bathing and worshipping as well as to observe fairs. In the fairs of *Kāttike Thuli Ekādashi*, traditional games like *Chhelho Ngāpke* (shut put), *Kapardi*, wrestling (kusti) and volleyball competitions, etc are organized on the bank of Kāligandaki river. Ritually, the Magars do not perform plantation of *Tulasi* herbs in the household but they celebrate this festival. Some Magars take fasting and bath into Gandaki and pray. On this day, the *Ghānto* dancers, *gurumā* of Ghānto and relatives go to Kaligandaki river. She takes the first bath before *ghantudi* and starts trembling and guardians carry her back to Gandaki and they bathe. *Gurumā*s of Ghanto sing songs and make calm for *Ghānto* dancers and returned home. On this day, the new dancers are also tested whether they have been caught by *Ghānto* god or not. If they have been caught by Ghānto god and goddess, they started to tremble and finalize to dance *Ghantu* and dancing period. At the fair, local oranges are available from nearby villages. There is a belief that bathing in the Kaligandaki rivers in these festivals helps to keep people healthy and good fortune from the deities (based on the conversation with key informants).

(x) Pandhra Push

The *Pandhra Push* festival falls in December. In this festival, the Magars invite their relatives and arrange a feast. On this day, *hyāk* (arum) is cooked through boiling and taken as special food. *Rodi* and other dances are arranged in the villages for entrainment. Recently, most of the Magars are giving less interest in celebrating this festival. However, the neighbouring Gurungs celebrate it as a *Lhosār* (New Year) in their community (based on the conversation with key informants).

(xi) Māghyā Sakarāti

Māghyā Sakarāti is celebrated as a New year day among the Magars and remembers ancestors, offering the ancestors doing *muthi dāke* (Baral, 2050BS, Shris, 2073 BS, Sinjali 2016). This festival is considered as bringing warmth and spring season because the sun's warmth moves from the southern hemisphere to the northern hemisphere of the earth due to the movement of the earth and the sun. On this day, the Magars remember their ancestors performing *muthi dāke* into water resources or steams. There is a belief that performing *muthi dāke* in *Magyā Sakarāti* ancestors bless them, give power for good health and good fortune. Performing ancestral offering on this day, it is also needed to offer other days within a year. But in recent years, with the influence of Brahmin culture, the Magars are also learning to perform *Sarādde* in *Sohra Sarādda* period of *Dashain* festival and taking *Tithito do Sarādde* calling a Brahmin priest. After offering to the soul of ancestor *muthi dāke*, they offer to *tikā* for unmarried virgin girls, daughter or sisters and her kin *kutumba* relatives and gifts (*dakchhinā*).

In Maghyā Sakarati, festival fairs occur on the bank of Kāligandagi river such as *Rāmdi*, *Rhedi (Ridi)*, *Andimohan*, *Setibeni*. The Magars participate in such festival fairs by playing *mādal*, *khajari* and other local-folk musical instruments, singing folk songs and dancing. They return to their villages accordingly. However, at present, such practices have been decreasing due to haphazard development, modern mass media, availability of audio-video songs, gazettes, etc. In this festival, the meat, *Bārā* and varieties for the celebration are prepared on the last day of Poush month. In cooking *Bārā*, they make in the shapes of various animals such as an elephant, rhino and other wild animals. In the feast, yam, arum and other edible round roots like *githā*, *byākur*, etc. are cooked and eaten. In eating such kinds of foods, they believe that they keep them healthy. In this festival, the Magars invite their relatives and feed them (based on the conversation with key informants).

(xii) Basanta Panchami

Basanta Panchami is also known as the day of wisdom god (Saraswati). On this day, new work is started such as starting to plough for calf (*bāchchhā dāidike*), learning new skill and so on. In some places of the study area, they do *younāt* worship to sow seeds in the field. After worshipping *younāt*, the *ghāntu* dance is started in *ghāntu* dancing area Ramche, Chitung, Pātikharka and Gwadi villages of the study area. On this occasion, *khitryā* (khichadi) food is cooked which contains the *mugi* (a kind of lentil), *techho* (black gram) and rice with some ghee and spices. Before two/three decades, they used to celebrate this festival inviting relatives and arranging feasts, but this scenario is being changed to a decline. The government and non-government schools arrange worship programs to the god of wisdom. Media also broadcast news about the god of wisdom and worshipping beliefs. Therefore, school children go to worship to the God of wisdom organized by their schools (based on the conversation with key informants)

(xiii) Yaunāt

Yaunāt festival is celebrated in *Phagu Purnimā* according to the Nepali calendar. But in the high altitude, the Magar villages of Pelakot Pidikhola, Nibuwakharka VDCs, the *Younāt* worship and festival are celebrated in Basanta Panchami. In *Younāt*, the Magars worship seeds of corn, seeds of arum, agricultural equipment such as hur (spade), hār (plough), sickle, etc. In worshipping, they do *nātle* (holiday) in agricultural work. After doing *Younāt* worship, seed plantation is opened in the villages. In *Ghantu* dancing areas, after *Younāt* worships at Basanta Panchami, they start Ghānto, a lyrical drama. In Chandibhanjyang, Birgha, Alamdevi and Krishna Gandaki VDC, they perform *Jiwai-Mama* folk dance and songs. Similarly, in the past, *khopyā*, *topyā*, and *lahuryā* dance were also performed, but nowadays they are not. In other villages, *Younāt* songs and dances are performed in *Phāgu Purnimā* but nowadays the custom is disappeared. The guests from the relatives are invited and feed them on the occasion of *Yaunāt* festival (based on the conversation with key informants).

(xiv) Chaite Dashain

Chaitra month is the last month of the Nepali calendar in which *Chaite Dashain* festival is performed in the study area. The festival is not celebrated grandly or extremely as like *Badā* Dashain. In this festival *kot* (fort) *pujā* is performed sacrificing a chicken, he-goat, he-buffalo, *bomasyā* (ash gourd or ash pumpkin), *sārapāti*, *achhetā*, *dhajā*, etc. In *Astami* (8th day) the villagers give sacrificing to worship commonly for weapons of *kot*, *khondā*, deities. In *Nawami* (9th day), *Panchabali* (sacrifice of 5 different living beings), sacrifices chickens

and offering *achhetā*, *dhajā*, etc. They invite relatives and feed them on the occasion of the festival. Furthermore, *Rodi* and *Jhamre* dances are also arranged for entertainment. After worshipping at Kot (fort), the *Ghānto* dance is performed (based on the conversation with key informants).

(xv) Other Feast and Festivals

The Magars of the study area, *Ausi* and *Purnimā* of the lunar calendar are considered as the festivals and have a *nātle* (holiday) from agricultural works. In most of *Ausi* and *Purnimā*, they invite married daughters or sisters and close relatives and feed them. However, such customs are in the line of dying. Besides this, the new festivals and customs are appearing in the Magars society which was not being celebrated in the past. Nowadays celebrating birthday, English New Year, Valentine's Day, and Christmas are gaining popularity among the Magars due to the impact of westernization, English medium schools and media. Similarly, celebrating '*Rākhi*' culture in *Janai Purnimā*, using colors in *Phāgu Purnimā* and losing their traditional song to *Phāgu*, etc are the influence of Indian media and culture among the Magars in Nepal.

5.3.4 Folk Songs and Dances

The territory of the ancient Magarānt area was rich in folk songs and dances. Baralmagar (2050BS) has found *Sorathi*, *Ghantu*, *Kaurha*, *Yaunach* and others like as *Jiwaimama*, *Jhora*, *Oholi*, *Jayure*, *Sālaijwo*; and folk songs such as *Yānimāyā*, *Sunimāyā*, *Nirmāyā*. Similarly, in agricultural work and feasts they sing *Salaijwo*, in Bhadau Month *Jhorā*, Ashoj to Paush months *Sorathi* (Nachari), Magh to Ashar Month *Ghantu* and *Kaurha* songs and dances used to be held in the Magar villages (Baral Magar, 2050, pp.85-118). But at present situation, most of them are disappeared in the study area.

The majority of national folk songs and dances are based on the ancient *Magarānt* area's production. The territory was a mosaic of local indigenous culture and southern culture in the medieval era of history. However, Magar's identity on folk songs and dances was sufficient till the end of *Rana* regime. Later on, Nepali society has been changed and more folk songs and dances of the Magars disappeared. Today, nobody knows about many old lyrical and musical tunes as they have been already forgotten. The young generation is not educated in this matter among the Magars. Besides, the government of Nepal has shown no curiosity on the protection of such intangible heritages of the Magars of Nepal. The haphazard development without safeguards and migration in the study area is contributed high in losing folk song, music and dances. It is stored only in the memory of senior citizens. In such a

situation, here, some folk songs and dances which are found in the study area and related to health, illness, well-being and entertainment are discussed on basis of the conversations with key informants, observations and focus group discussions.

(i) Ghānto

Ghānto is locally pronounced as *Ghāntu*, a folk lyrical drama. There are three types of *Ghānto*: (1) *Rāchya Ghānto*: Dancers dance with *Jhānk* (shaking/trembling) due to supernatural power, (2) *Mārāchya Ghānto*: dancers dance without trembling, and (3) *Bāhramase Ghānto*: Ghānto danced anytime of the year for entertainment (BaralMagar, 2050 BS, pp 97-101). In the study area, only *Rāchya Ghānto* is in practice and related ill-health and healings (Sinjali, 2070 BS, pp 1-14). Currently, only Ramche of Pelakot VDC, Chitung of Pindikholā VDC and Gwadi of Nibuwakharka VDC have Ghānto practices whereas it has been completely disappeared from other villages. In Garangdi of Jagatravi VDC, they only worship Ghānto god. The stories of the Ghānto of the study area are based on three kings *Rithubartan (Ritubarta)*, *Kailāsh and Narsing (Nareswar)*, and three queens *Satyawati, Biddhyāwati and Yambawati*. The *Ghānto* story describes the kings and queen's birth, childhood, agricultural works, household works, hunting, politics and ruling, diplomacy, warfare and war with neighbouring countries in lyrics. The lyrics have slow and long tunes and dances are slow with symbolic meaning. The dancers dance closing their eyes. The story ends in a war where the kings die in the war. Listening to the sad news of war, the queens become fainted. When they (queens) are awakened to consciousness, the *Ghānto* lyrics are finished. In the Magar language, *Sotke* means to make consciousness, awake from sleeping. Therefore, *Rāchya Ghānto* is also known as *Sati Ghānto*. This lyrical drama has a tragedy about the kings and queens caused by wars, therefore, it is a tragic lyrical drama.

In the study area, the singers, directors and dancers of the Ghāntu are women. One adult or senior woman becomes *Raurā* (director) and other singers, and *Raurās* are also called *gurumā*. The dancers are generally unmarried girls but married women could take part. Dancers come from those families that they have fallen ill themselves or their family member falls in illness or does not heal from the modern health care system. In such situation, *lāmā* or *wārchā bharmi* refers to Ghāntu and Ghāntu Gurumā test them into Ghāntu dancing period or in *Kāttike Thuli Ekadasi* through bathing in *Ghāntudi* and *Kāligandaki* river custom. In this process, they are caught by one god among the three kings and three queen gods. Then she performs that god's role for 3 to 5 years or more. In dancing, *gurumas* match the pairs of kings and queen gods and provides acting roles. In contrast, if a dancer (locally called

ghāntoko, and in places also said *ghāntu kanyā* or *bayāni*) could not get her pair, then she should play both roles of king and queen until she gets her pair. In the study area, there is no limitation in the number of dancers. On the researcher's observation on *Buddha Purnimā* of 2070 BS, there were 23 dancers in the Rāmche village of Pelakot VDC. The dancers have *Sotharmā* (caretakers) and they help with decoration, dressing up or makeup and problems arise during dancing period. And brothers or fathers help them on carrying them to dancing place to ending custom place which could be a few minutes away walking from the dancing places. The unmarried boys prepare *Umarā* (or priest) and the *umarās'* worship places, worshipping goods and sacrifice chickens for god and goddess.

In the study area, *Ghāntoko* (ghāntu dancer) selection and start date is *Kāttike Thuli Ekādashi* and dance is performed from the *Basanta Panchami* (Shree Panchami) and dances every full moon day and ended on *Buddha Purnimā* (lord Buddha's born day). The dance performance occurs one to three days on one occasion. On the end day of Ghāntu, *Gghāntu Seladike* rituals are performed in the evening. On the following day, a feast is organized which is called 'Bhailo Mhāske'. *Bhailo* are the audiences or visitors who give some money to promote culture, and further dancers and villagers collect some Bhejā to conduct *Ghānto*. That fund is finished doing feast. The *Ghāntoko* (dancers) abstinence garlic, pork and some other foods from *Kattike Ekadasi* to *Buddha Purnimā* and the *Bhailo Mhāske* feast opens to eat all things for Ghāntu dancers. This dance is related to health and many households healing from this performance (based on the conversation with key informants and observation on *Buddha Purnimā* of 2070 BS and 2072 BS).

(ii) Mārūni/ Sorathi

The Sorathi/Mārūni is also a lyrical drama. In this dance, there have been sixteen different beats or musical tunes of *Mādal* and sixteen parts of the lyrical drama. Locally, it is also known as the 'Karhāng Nāch'. In Tanahun and Palpa districts, it is also known as 'Nachari' (Hitchcock 1966, p. 92), *Pāndure nāch*, 'Nachanyā' (BaralMagar, 2050 BS p.86). To perform this lyrical dance, teams are needed: a singer team and a dancer team. The singer team is called '*Garrā*', and the director is called *Raurā*, and the second leader is called *Guhyā*. In the singing moment, one team is led by the director *Raurā* and the first *Raurā* sings followed by his followers. After finished by *Raurā* team, the *Guhyā* sings followed by his team. After *Guhyā* team finishes, again the *Raurā* sings new words and is followed by the followers. This circulation occurs until it is finished. In the dancer team, around three to four male adolescences are dressed as females and actfemale roles, and they are called '*Mārūni*'. One

one male dancer is called '*Pursungge*' or '*Mijhāwaryā*' which is the main leader of dance paying the role of the king *Jayasingge*. Similarly, *Mādalyā* plays the *mādal* and dances with *Mārūni* and *Pursungge*; and *Mokharyā* acting as a comic and creates a laughable environment. This, being a social and religious dance, starting is done at *Badā DashainKālāratri* with worship god (Devi Bandhan/ Devi Dhyākke) and closed at *Phāgu Purnima* (Holi) with worship (Baral, 2050 BS, pp.94-95) and in some places, it is closed on Buddha Purnimā.

The stories of the Sorathi/Mārūni lyrical dramatic dance are based on the king and his two wives, his daughter, conspiracy of stepmother with buying king's priest and astrologer about telling fault fortune of his daughter for the kings and consequence events. In this dance, farming and livelihood, fishing and boating, pot-making art, ritual (birth, marriage), politics, illness and medications, royal family moving for hunting in the jungles, conspiracy and diplomacy have been described. Therefore, it teaches about human life, society, skills and social life as well as gives cultural entertainment. That's why it has sociological values to construct and conduct the society among the Magars. In the study area, this dance is also conducted in weaning ceremonies (*bhātkhuwāi*) and feast and festivals. But these days, this dance is in endangered condition as the old Magars who were expert are going to expire due to old age. Likewise, the young generation is highly migrated to urban areas or abroad in search of jobs or looking for a better life. Besides, child education in the urban areas and the influence of Nepali, Indian as well as western media has contributed to the extinction of such traditional and cultural songs and dances. Therefore, in most of Magar villages like Nibuwākharka, Pelakot, Pindikhola, Jagatradevi VDC, Sorathi/Mārūni folk dances had not been organized for one/two decades and other VDCs are also organizing sporadically or rarely (based on the conversation with key informants).

(iii) Younāch

By ritual, this form of dance starts on *Basanta Panchami* (day of Saraswati Pujā) at night. Youth and adults gather at *Kolhu* (traditional wooden machine to produce oil) and sing songs with the lyrics related to sexual activities (*Aslil lhing*) in Magar language with worshiping *Kolhu*. Later on, they sing songs related to Ramayan or Mahabharat saying backward and this ritual was called *Yaunācha Jagadike*. At *Phāgu Purnimā*, they sing songs in socially accepted words in their own original vocal tune and dance for three to four days roaming household to household collecting *bhailo*. And they perform a closing ritual on the coming day of *Phāgu Purnimā* with worshiping and sacrificing a chicken. Again in closing ritual, while

worshipping, they sing vulgar songs in Magar language (BaralMagar 2050, pp. 116-17). But nowadays, such a *Younāch* is not found, in the village *Kolhu* system are displaced by modern mills. The *Phāgu Purnimā* custom is replaced by *Holi festival* of Indian culture and young generations are entertaining aggressive use of colors only. The initial inaugurating ritual custom and ending (*Yaunāch Seladike*) custom songs were shamelessly related to sexual activities which helped to release mental tension from the body. In another way, it also provides entertainment for good health and sexual health education too (based on the conversation with key informants).

(iv) Jiwai-Māmā

Jiwai-Māmā is lyrical dance. This is also called *Jyomāre* in Rukum and Rolpa districts and generally performed in *Phalgun* month or *Holi Purnimā*. In the study area, after *Yaunāt* worship and festival, this lyrical drama is performed. *Younāt* worship and festival is a symbol of opening for plantation corns or cultivation: seeds of corns and vegetables, agricultural equipment such as plough, spade, and sickle and so on.

The story of the lyrical drama is based on *Māmā* and *Bhānjā* conversation about the marriage. The *bhānja* (son of sister) has been requesting to maternal uncle (*māmā*) in permitting him (*bhanja*) to marry his daughter. In the song, *sāli* and *bhenā* fall in love, but maternal uncle do not give permission to marry. Maternal uncle denies giving his daughter to his *bhanja* because he wants a capable and efficient *bhānja* to marry his daughter. As the conversation goes for a long time, finally, the maternal uncle agrees and the marriage ceremony starts for a new family, then, this lyrical drama ends. In the study area, the *Jiwai Māmā* lyrical dance is performed in Alamdevi and Chandi Bhanjyang VDC using the period of *Phāgu Purnimā* or *Holi Purnima* in *Yaunāt* festival. However, the Magars from other VDCs have already lost this dance (based on the conversation with key informants).

(v) Jhorā

In recent years, the folk dance and songs of *Jhorā* have been disappearing from the study area. *Jhorā* was sung and danced at the *Teej* festival. The media and the government give emphasis on modern *Teej* songs only whereas had not shown any interest in folk dance and songs like *Jhorā* of Magar culture. In the time being, the Magars are also attracted towards modern *Teej* songs and dances. As a result, *Jhorā* got disappeared from the Magar society. It is a slow rhythmic tuned song and danced in slow motion with symbolic meaning with the slow beats *mādal*.

The key informants of the Jagatradevi VDC informed that in the village Garangdi, some senior women know *Jhorā* songs and dances, but young generations are unknown about this. There was a belief that if all the rituals of *Jhorā* could not be followed, people might be caught by *Ghānto* god and fall into illness. Therefore, it was not practiced in the villages because expert *gurumā*, *mādale* were not in there (based on the conversation with key informants).

(vi) Jhāmryā

Jhāmryā also called *Jhābre* (Hitchcock, 1966, p. 91), *Jhāmre*, *Jhāpre*, *Jhyaure* and so on pronunciations in different places. This folk song and dance performed on any occasion like marriage function, worships, or feast and festivals for entertainment. In the study area, it has seven different musical tunes of *mādal* and which start from slower beats, go faster and end in faster beats. The song lyric is repeated seven times slower to fast. The *Madal* is beaten seven tunes with the lyrics. Anybody who dances in this performance performs slower to fast, and sitting -standing (*uthyo-basyo*) acting. This provides good physical exercise, entertainment for maintaining health (based on the conversation with key informants).

(vii) Rodi Muke

Rodi is an entertainment club developed in the civilization process of ancient Magarat. It was also a traditional social institution. It was a factory producing intangible heritages of Nepal in the sector of folk dance, music and song of ancient Magarat. *Rodi Muke* is joining in *Rodi club* or *Rodi im* activities. In the study area, the infrastructure of *Rodi im* has been completely disappeared after the restoration of the democracy of 1991. However, *Rodi* culture is still in practice. Actually, young generations are not interested in Rodi, so such folk culture is in an endangered situation. The *Rodi Muke* is generally arranged in the feast and festivals, coming *lāhure* in the village and other special occasions through the adults, married persons to survive cultures.

Before three/four decades, youth males and females used to gather in the evening. They used to sing songs about love, affection, marriage, after-marriage life, household activities and future plans between boys and girls in the form of conversational lyrics. There used to be a leading singer in boys groups and girls each. When the leading person of boys sings lyrics, then others follow after him. The leading girl gives the answer in lyrics and is followed by others (Hitchcock, 1966, BaralMagar, 2050BS, Shepherd 1982). In *Rodi*, the songs are sung having slow-motion rhythmic tunes such as *Sāli jyu*, *Yāhāni Māyā*, *Suni Māyā* and so on.

The *Rodi Muke* has been giving entertainment and teaching socialization, creation of new music, song and dances to youths and villagers through gathering. They talk about livelihood matters, household matters, health and illness, well-being, indigenous knowledge and skills as well as acquired knowledge sharing. Hence, the *Rodi Muke* helps persons to know other's health, knowledge about health though there might be chances behavioural deviation among the youths (based on the conversation with key informants).

(viii) Other Folk Songs and Dances

Three/ four decades ago; Magars were rich in folk song and dance, and cultural activities. But, their intangible heritages could not get entry in mainstream media, education system and society of nation. Therefore, many folk songs or dances disappeared and some are in endangered conditions. In the villages, the singing tune of *Sāli jyu*, *Yāhāni Māyā*, *Suni Māyā*, *Thado Bhāka*, *Laske Bhāka*, *Chudkā*, etc. songs are declining and endangered. The *Khopyā Nāch*, *Topyā Nāch* and *Lāhuryā Nāch* on the occasion of *Younāt* worship and festivals are also disappeared. There used to be separate songs in *Phāgu Purnimā* festival, on the occasion of planting paddy and millet, weeding of millet and paddy field, collecting season of corns and food grains, carrying fertilizers in the field works whereas they are not in practice these days. Similarly, while cutting grass or working in the field, there were jingling or clinking sounds of melodious and heart-touching songs. The persons used to express their pains, and give information through the songs which were helpful to their mental health keeping them free from tension, waiting for a bright future and sustaining life. But, such an environment of the villages is not found today (based on the conversation with key informants).

5.3.5 Deities and Worships among the Magars

The Magars have several deities to worship and different names in different villages for well-being, ill-health and healings. Shepherd (1982) found more than 58 deities worshiped by the Magars of Arkhala village of Nawalparasi district. Some gods (or goddesses) might be related to only one household or clans and worshipped only by them. Some gods may be common among the villagers and some are common among the Magars. Among the Magars, they did not have a practice of worshipping an idol (statues of god) in respected deities' *thān* (temple). They generally prepared *thān* erecting two stone and roofing by another stone in worshipping time. They smear (*lākke*) *thān* using water, mud and cow-dongs, and plantation of *titepāti* attaching *thān*. They sprinkle alcohol or liquor surrounding *thān* as sanitizers. Then they sacrifice a chicken, duck, goat, etc. at the *thān* and give blood (*bhog yāhake*) to blood-eating deities. However, Hitchcock (1966) has described deities as *bhog jyāch deutā* and *bhog mājyācha deutā* categories (p.25). However, there is a fluidity about this category because some Magars do not give *bhog* (blood) to some deities and give *dhār* (offering by rice pudding and other items); but other Magars can give *bhog* for the same deities. Hence, BaralMagar (2050BS) argued that it is difficult to divide Magars into categories in terms of sacrificing blood. On the other hand, Hitchcock (1966) has tried to categorize into god, goddess and godling (local gods). However, the Magars give the same values to all deities. Most of the deities are offered for believing that they are related to illness, misfortune, healing, good health and prosperity. Here, some deities are mentioned based on the information obtained from the conversation with key informants, observation and focus group discussions from the perspectives on the perception of health.

(i) Pitri puja

The Magars have a belief in the souls of ancestors which can protect them from illness and misfortune. So that they worship and remember the *pitri* (ancestors and dead parents) in every feast and festival and offer foods that they have cooked on the occasion of feast and festival. Only after offering the foods for *pitri*, they eat foods. But ritually, the majority of the Magars have do *pitripujā* (worship of soul of ancestors) mainly on the occasion of *Maghyā Sakarāti* and *Dashain* festivals. Among the Magars of the study area, *pitripujā* is known as '*muthi dāke*' and somewhere '*di dāke*'. In *Dashain* festival, *pitripujā* is done in *Jamare Aunsi* of *Badā Dashain* festival and this is also known as *Pitri Aunsi* and *Umarā Khalak* repeated *Pitripujā* on *Astami* (8th day) of *Dasain* festival by sacrificing a chicken in kot (fort). However, if other dates are missed for *pitripujā*, then only doing in *Māghyā Sakarāti* is

considered enough remembering their ancestors. After doing *pitripuja*, the worshiper gives *tikā* and *dakchhinā* for *chelibeti* (virgin girls, married daughter or sisters) and they arrange a feast inviting relatives (based on the conversation with key informants).

(ii) Kulpujā

Kulpujā is also traditional worship for ancestor's soul and remembering them where the ancestors become common of the clan or *bhāikhalak*. The *bhāikhalak* are common descendants of that ancestor or ancestors. The *Kulpujā* is own clan's matters, therefore, the dates and procedures of worshipping vary according to the clan. Some clan do *Kulpujā* at *Badā Dashain*, some clan do at *Buddhā Purnimā* or *Chandi Pujā* day, some clan do with *Bajebajai Pujā* or in *Mangsir* month, some do in *Baisakh* month, etc. In *Kulpujā*, some clan invites all relatives and feed feast but some clans celebrate feast within *bhāikhalak* and remainder food is buried. Some clans prohibit pregnant women and their husbands from taking *Prasad* or join the feast of *Kulpuja*, but some clans allow it. But, pregnant women's husbands cannot become *Umarā* in *Kulpujā*. Majority of the Magars of the study area sacrifice pig, chicken in the *Kulpujā*, however, some clans sacrifice sheep and chickens. They have a belief that the *Kul Deutā* (common ancestor god) protects them from illness and misfortune. Therefore, *Kulpujā* should be conducted fulfilling all traditional custom or ritual in a chronologically, neat and clean manner (based on the conversation with key informants).

(iii) Chandi Pujā

Chandi Pujā is generally done in the *Purnimā* of *Baishākh* month or Buddha Purnimā. But, there is no fixed date or day to perform Chandipujā among the Magars. Generally, they perform Chandi Pujā from *Achhaya Tritiyā* (3rd day of the new moon of Baisākh month) to *Purnimā* (full moon day) of Baishākh month. The mature adults are suggested that it is better to complete *Chandipujā* within the 22nd of the *Baisākh* month (BaralMagar, 2050 BS, pp. 124-125). *Chandipujā* is being done collectively by all villagers, and the organization is called Chandi Bhejā. In the past, Chandi Bhejā was a powerful organization as they used to pass the policies and regulations of the villages. Similarly, victims who were not getting justice for a long time used to be provided with justice. It was also for selecting the chiefdom in the village whereas this tradition is disappeared.

Among the Magars, Chandi Pujā is the worship of nature. In Magar language 'chan' means 'electric shock of cloud' and 'di' means 'water'; and etymological meaning is worship for 'rainwater'. In this pujā the shaman or wārcha bharmi predict the raining strength, floods and cultivation pattern by seeing the sacrificed blood of pig and observing buried egg at Chandi

thān. The buried egg is such an egg which was buried in the past Chandi Pujā (Sinjali, 2071BS, pp 21-29). This worship is related to nature and raining which helps in the production of corns or food grains and vegetables. If agricultural production becomes good, then the nutrition of the villager would be better for a healthy life (based on the conversation with key informants).

(iv) Māi/ Māyu Pujā

Mai/Māyu Pujā is done collectively gathering villagers. *Maipujā* also called Sansāri Māi, *Samikchhā Pujā* etc. This worship is performed in *Mangsir* and *Baisākh* month of the Nepali calendar. The villagers collect bhejā for worship, they gather and make thān and sacrifice goat, chicken, pigeon for *māi/māyu deutā*. They have a belief that *Māi Deutā* prevents them from an epidemic illness like smallpox, measles, cholera, etc. and also guards the village from *Desān* (epidemic) of illness (based on the conversation with key informants).

(v) Bāyu or Bāi Pujā

Bāyu Deutā is the ancestor spirit. There is a belief that the soul of death person is goes to *boikungthaun* (pitrilok). The *boikungthaun* (pitrilok) could be in hills, mountains, rivers, water resource or within nature. But, soul of *Lāmā*, sage (dhyāni) and *Boksi* (witch or sorcery) could not reach *boikungthaun* (pitrilok) after their death, the spirit would roam surrounding household or villages. Similarly, the soul of immature death due to accident, suffocation and so on roams surrounding households and villages. This type of bāyu spirit is called *mari bāyu*. The *mari bāyu*, witch/sorcery *bāyu* could cause illness and misfortune. Similarly, sage spirit, *Lāmā* (shaman/philosopher) spirit protect the households or descendants from illness and misfortune. Therefore, they do the worship or bāyu. In *Bāyu Pujā*, they make a *thān*, spear the *thān* making place, burry *titepāti* plant's *linggo*, and sacrifice the chicken naming with known *bāyu* and unknown named *bāyu deutā* (based on the conversation with key informants).

(vi) Bhuyānr Pujā

Bhuyānr is also an ancestral spirit. The spirit of dead ancestors who were *Lāmās* (shaman) or sages (philosophers) or *tapaswi* is considered as the *Bhuyānr Deutā*. It is also considered as common ancestors of clan or villagers and somewhere is it also said the *bhummyā* too. *Bhuyārs* are several types such as *Budhā* Bhuyānr, *Jal* Bhuyānr, *Ban Jhānkri* Bhuyānr, Sun Bhuyānr, Rittha (kalo) Bhuyānr and so on. The *Bhummyā Deutā* is also considered as Bhuyānr, therefore, *Bhuyānr Deuta* is also worshiped in time of *Bhummyā Pujā* which is done in *Chaitra* to *Saun* months on different dates in different villages according to their convenience and

tradition. *Bhuyānr Deutā* protects from illness and misfortune and helps to good agricultural production (based on the conversation of key informants).

(vii) Bhumyā Pujā

Bhumyā is also the spirit of ancestors and worshiped in *Chaitra* to *Saun* months. In the study area, *Bhumyā Pujā* is done Syālbās of Pidikhola VDC and Alamdevi and Chandi Bhanjyāng VDCs. The *Bhumyā Pujā* is also similar to *Bhuyānr Pujā* and related to ancestor spirit and cultivations (based on the conversation with key informants).

(viii) Harelo Pujā

Harelo Pujā is related to agriculture and the cultivation of rice. Generally, in *Bhadra* month of the Nepali calendar, *Harelo Pujā* is performed in the paddy field. The rice pudding is cooked and sacrificing chicken making *thān* at paddy field and burying *titepāti linggo*. The worship is for expecting good production of grains which provides nutrition for humans to keep better health (based on the conversation with key informants).

(ix) Chhomyāng Pujā or Nwāgi

Chhomyāng or *Nwagi Pujā* is done after the ripening of the grains. In Magar village, *Nwāgi Pujā* is performed every time of ripening grains such as maize, millet, rice, etc. In maize ripening, the plant of maize with corn offered to *Bhuyānr thān* or *Bhumyā*, then remembered the all ancestors, gods and goddess. Then they do give *dhup* and newly corn to *deutā*. Then they eat new corn. Similarly, in rice ripening, new rice is cooked and offered to ancestors, *Bhuyānr* and all the gods and goddesses, then, they start eating new harvest (based on the conversation with key informants).

(x) Deurāli/ Bhāngjyāng Pujā

In the study area, the Magars worship the pass between two mountains called *Bhāngjyāng* or *Deurāli*. This is worship to nature. The *Bhāngjyāng* gives a shortcut way to go to another village instead of going hiking in the hillside to visit another village. They think that their ancestor's spirit is there in the *Bhāngjyāng*. They make *thān* and worship sacrificing goat and chicken. This *pujā* is done collectively by the villagers collecting *bhejā* (based on the conversation with key informants).

(xi) Onghyā, Sirung and Kholākhāli Pujā

The Magar *deutā Onghyā*, *Sirung* and *Kholākhāli* can be responsible to cause illness and misfortune. *Onghyā Deutā* lives in wetlands (*dhāp lechha gāhārā*) and is worshiped sacrificing a pig. *Sirung Deutā* lives in the water source (*dī phuhucha thāun*) and is

worshiped with a chicken or a goat. These *deutās* (gods) are also considered as *Nāg Deutā* (snake god). In general *Kholākhāli Pujā* is also the worship of the *Onghyā* and *Sirung*. If such worships are not carried out, they can cause illness. The Magars generally make *thān* in water source naming *Sirung* or *Kholākhāli Deutā* and keep cleanliness. There is also a belief that if someone does defecation or urination near *thān*, the *deutā* punishes him/her causing illness or misfortune. Worshiping in the water resources or stream would help to keep sanitation for good health and prevention from water-born communicable illness (based on the conversation with key informants).

(xii) Sikāri and Banaskhandi

Sikāri and *Banaskhandi* are hunter gods. Generally, this deity is worshiped if someone falls ill at household or promising (bhākal) to deity in falling illness or troubles. The *Lāmā* or *Wārch Bharmihas* indicated or diagnosed the illness caused by *Sikāri* or *Banaskhandi* deity, then s/he suggests to the worship. In past, the deity was worshiped with other deities (e.g. *Māyu/Māi Pujā*) together yearly. Nowadays worship of deity annually is slowly going to disappear (based on the conversation with key informants).

(xiii) Bājibajai and Mandali Pujā

Bājibajai (grandfather and grandmother) *deutā* is called *lhumpeki bājibajai* in the study area³. *Lhumpek* is the next side of *Kāligandaki* River of the study area, lies in Gulmi district. But in eastern Syangja, Tanahun and Palpa districts, it is called *disingkote bājibajai* or *bājibajai pujā* only. These ancestor gods *bājibajai deuta* were the superhuman having supernatural power (Hitchcock 1966; BaralMagar 2050 BS; Shepherd, 1982). They were able to do surgery on the internal organs (hearts and liver) and keep them out from the body. Again, they had the capacity of fixing those organs into the same human body and give their life back. This *pujā* (worship) is done for remembering those ancestors, *bājibajai* who had supernatural power and practices. The *bājibajai pujā* is done in Mansir month and Baisakh months. The pig, chicken, pigeon, etc are sacrificed for *bājibajai* and a feast is also organized on that day inviting relatives. And *pujā* is conducted gathering all the villagers in one place. In the study area, the fashion of the worshipping *lhumpeki bājibajai* collectively by the villagers is going to disappear but they remember and worship to *bājibajai deuta* individually or at the time when someone becomes ill (based on the conversation with key informants).

³ Conversation with Khadka Bahadur Hitan, age 88/male of Rupakhani village of Nibuwakharka VDC on 25/01/2072 BS.

Another deutā named *Mandali* was also superhuman and having a superpower, but he was converted from a human into a tiger and remained a tiger. This worship is also done in Mangsir and Baisākh months of the year. There is a belief that *Bājibajai*, *mandali deutā* could cause illness when they became unhappy. In contrast, they can protect humans from illness and misfortune if they become happy; therefore, the Magars remember and worship them (based on the conversation with key informants).

(xiv) Worship of Evil Spirit

The Magars do worship or offering of evil spirits like *bhutpret* (ghost), *Masān*, *pichās*, *rakshesh ledheni/nidhini*, witch/sorcery and so on which are directly connected with health, illness and healings in the society.

Bhut, Prêt and Pichās/Pisād: The Magars believe in *bhut*, *prêt* and *pichās* (ghost). In past, these spirits were remembered and worshiped at least once a year. But nowadays, they are worshiped only when someone falls ill due to these deities. These spirits are worshiped away from the house where they have a big tree. They construct a *thān* there and then offer sacrifices. In *Lasarghābesi* of the Alamadevi VDC, permanent *thāns* are found constructed with a shed, beneath the bottom of the big tree. The *bhut* or *pret* or *pichās* could cause the *sāto* (a local illness) or eat the heart of the human or household animals. There have several stories of the *bhut* (ghost) where *lāmā* or powerful man can control the ghosts. They work in *gāhārā* or *bāri birhadike* (construction of agricultural field), transfer or displace huge stones, plantation of paddy, millet or corns and they take benefits, etc. But if some mistake had happened, the ghosts could have eaten the heart of the human (based on the conversation with key informants).

Masān: *Masān* is also causative spirit to illness among the study area. *Masān* pierces to human in walking or working spirit's way and probability become high in being alone or last of walking in the evening or night, in frightening conditions. In *ghāt* or cremation place, way of carrying a deceased person to cremation and lonely/solitary places, etc. have high chances of being *masān* spirit, therefore, people do not prefer to go in such places in the evening or at night. There may be roaming several types of *masāns* such as *bir masān*, *kali masān*, etc. The *lāmā* or *wārcha bharmi* can diagnose the spirit touching the pulse of the ill-person or examining *achhetā* touched by the ill-person. The *achhetā* and water move around (right to left way) up of the head of ill-person promising worship. Then they go to worship to the direction of *masān* suggested by *lāmā* with taking *achhetā*, water, fire charcoal and turmeric powder. This is also called *masāsan charhaitke* or *lohoke*. Here, sacrifice is not offered. The

water is returned and few drops are sprinkled forcibly on to the ill-person; then it heals to the ill-person (based on the conversation with key informants).

Ledheni/Nidini: *Ledhini* or *Nidini* kidnap the persons and take with her to *Odār* (caves), and keep with her. Such kinds of ill-persons could stay in the cave for several days; and sometimes difficult to find out from the villagers. *Ledhini* or *Nidini* sometimes pierce the persons and cause fall into illness. Generally, this spirit causes mental illness. The *lāmā* diagnose causing spirit and refer to the direction and cave to worship. To *Ledhini* spirit, the female cosmetic goods like *dori*, *kānchi*, *gel* (bangle), *tika*, female cloths, etc. are kept in torn and broken *dhākar* (a kind of bamboo basket) which is offered by walking back to the cave. After offering for the *Ledhini/Nidini*, the ill-person becomes healed (based on the conversation with key informants).

Rakchhes: Generally, *rakchhes* do not cause illness because there was a belief that *rakchhes* were the ancestors of the god. But, sometimes, if they get angry with human beings, they eat the heart of the human immediately and the person dies immediately. If, the shaman (lama) diagnosed *Rakchhes*, then he does *Bhakal* of worship or doing worship which heals the patient (conversation with Tilbikram Rana, 80 yrs of Birgha-1).

(xv) Witch/Sorcery (Boksi/Boksā)

Among the Magars of the study area, there have been found beliefs in witchcraft, sorcery (*Boksi/boksā*, *risāni*) in the causation of illness for human and household animals. The children of witch or sorcery are called *chhaundā* and witch or sorcery send to invade or pierce someone for giving troubles or cause illness. *Lāmā* or *wārcha bharmi* diagnoses the witch (or sorcery) in the causation of illness, and *poksā lohoke* (offering for witches) has been done to witch or sorcery. In *poksā lohoke*, four balls of *badāp* (ash) on a leaf (*lhā*), *mhegrit* (fire of charcoal) have been thrown into the cross road, at night. It is also called *pātlho lohoke*. Sometimes, an egg is also given for *chhaundā* of witches (based on the conversation with key informants).

(xvi) Other Deities and Worships

The Magars of the study area have been worshipping *Bhimsen Pujā*, *Siddhā Pujā*, *Simyābhūmyā*, *Bhairam*, *Jhānkri*, *Goth Puja*, *Barāhā*, *Thāni*. They also worship *Alam Devi*, *Balām Devi*, *Kots* (Forts), *Tamkikot Deutā*, *Lhumpeki Deutā*, *Akalā Devi*, *Khand (Khondā) Puja* and other local shrines. Similarly, they also worshiped *Palpa Satyadevi*, *Dhor Barāhā* and *Chhabdi Barāhā* of Tanahun and other shrines located in surrounding districts. Furthermore, they also worship Hindu gods and goddesses such as *Jagatradevi*, *Kalika Devi*,

Bishnu God, Laxmi, Saraswati, Bramhā, etc. as well as Buddhist Gods too. In addition to this, some Magars also worship Christian gods and goddesses. However, the worships of the god and goddess or local gods have been worshipped because they cause illness or protect from illness and misfortune (based on the conversation with key informants).

(xvii) Nātle and Bārdike

Etymologically *nātle* means holiday. Generally, the Magars have holidays on *Aunsi* and *Purne*, festival periods, *pujā ājā* (worship ceremony). The *nātle* gives rest for the agricultural workers and it also provides recreation, entertainment time for the villagers. Such a system is helpful to health. Similarly, when *jherlung* (hailstone) fall into villages, at that time, they worship keeping iron *ārhum* (*odān*) on the opposite position in the *ārbhā* (courtyard of a house) and next day they said *bārdike* and do *nātle* is called *jherlung bārdike* (worship of hailstone). The *jherlung bārdike* is performed once a year. Similarly, the Magars do *nātle* and *bārdike* of storm and hurricane once a year after the hurricane or storm enters into the villages. Thus, the Magars worship the natures for their good health and fortune, prosperity and prevention from natural disasters (based on the conversation with key informants).

(xviii) Promise (Bhākal/Garāngke) to Worship

The Magars promise to worship (*bhākal/garāngke*) for deities or god, goddess and godlings (local gods) for their healing of illness, improving misfortune and good health. It is also called *garāngke*. In falling illness or returning from the hospitals or chronic illness, they go to *lāmā* or *wārch bharmi* taking patient together or with *achhetā*. In some condition, patient touch the *achhetā* (rice grain, an amount of one *muthi* or *mānā*) when patient difficult to go into *lāmā* or *wārch bharmi's* house. They can also invite the *lāmā* or *wārch bharmi* into a sick person's home. The *lāmā* or *wārch bharmi* see the ill-person, check the pulse on wrist joints and other necessary examination and saw the *achhetā*; then he diagnosed the causative deities of illness. Then promise (*bhākal*) to worship for respected deities or evil spirits. In promise (*bhākal*) *achhetā* and water drop move to the round right to left in three times keeping an ill-person's head in the center. Then that *achhetā* is kept safely inserting into the roof. If sacrifice is required, a chicken is also promised to be sacrificed with *achhetā*. This process is also known as '*garāngke*' or *gwā garāngke* etc. The worship (*pujā* or *charhaitke*) is being done on the deities' scheduled worship date (if the worship is done collectively) or their own convenient time. There is a belief that if once promised (committed *bhākal*) for deities, and could not perform offering or forgot it due to other reasons; then again illness or misfortune could come in a household. Therefore, the Magars complete the worships of

deities according to their *bhākal* (promise) for respected deities (based on the conversation with key informants).

5.3.6 Dress and Ornaments among the Magars

The dress and ornaments are a part of the culture. It is based on their socio-economic situation, livelihood, geography and environment, social norm and values, social and global trends. Before four/five decades, the Magar used to wear clothes of *bhāngrā*, a type of clothing thread extracted from *gheu/ puwā orsisno* (nettle), bark of cannabis and other fibrous plants. Similarly, clothes from wool weaved in the home used to be used. Later on, the Magars cultivated cotton and weaved the cloths called '*Khādi*'. The male wore *Gādo*, *Kachhād*, *Bhoto*, *Langauti* (loin cloth), and a Cap sewed manually. The females wore *Gunyu*, *Cholā*, *Ghalek*, *Larphu* or *luhup* (*pachheura* or *mujetro*). The *Khādi* clothes were colored with mud or bark of trees. These clothes were called *pāngā* and both males and females used to tie-up *ghorpyāk* (*Khurpeto*) with *hansiyā* (Sickle-shaped knife). In Palpa District, the females who did not wear *Ghalek* were assumed as bad-mannered and *Larphu* in Syangja and Tanahun. Similarly, they use *Sirphul*, *Shirbandi*, *Chandrama Kānta* on the head; *Madhari*, *Shilmundri*, *Dhungri*, *Chepte* gold in the ears; *Phuli*, *Bulānki* in the nose, *Kanthamala*, *Muga*, *Jantar* in the neck. In the hand, *Raiyān* bangles were ornaments for female Magars. Furthermore, they also wore *pote* (*kanchi*) by both married and unmarried female, which is different than the other ethnic groups of Nepal. In such a way, the males also wore *Mundri*, *Kundal*, *Bijkani* and *Birbul* in the ear and silver *bālā* in hands. After world war-II, Gurkhas brought *Stākot* which was added in Magars (BaralMagar, 2050BS, pp.39-41). The key informants of the study area were also telling the information as mentioned by BaralMagar (2050BS) and noticed the change in the dress and ornaments in the Magar society.

Nowadays, the Magars wear modern clothes like shirt, pant, T-shirt, jacket, *daura* and *suruwāl*, *pījamas* and so on (males); and *sāri*, *blouse*, *skirt*, *kurtā suruwāl*, *T-sirt*, *lungi*, *lehengā* and so on (females) buying from the markets. The Magars are also attracted to fashion promoted by media, audio-visuals, and social media as well as the influence of globalization, mainstream culture and Indian culture. However, in identity-based programs, most of the Magars wear their traditional dresses and ornaments. In addition, the Magars main subsistence economies are based on Gurkha Army services, foreign employments; therefore, they have a deep interest in wearing such professional dresses as well as foreign-designed dresses and ornaments. About the culture of dress and ornaments among the Magars of study, they use words such as '*bherke*' for wearing shoes, socks and sandal (foot wares);

'*puhuke*' for wear cap and head wearing fashions; '*bilhke*' for wearing a shirt, paint or wearing of the main body; '*chhyākke*' for wearing belt or *mātha*, and *buke* for ornaments, watches, *tikā* in Magar language. This shows keenness in fashion. The Magars wear the dresses according to the climate and season of the environment to protect their health such as the thick and warm clothes in the winter season and thin and light clothes in the warm seasons for health and well beings (based on the conversation with key informants).

5.3.7 Food Habits and Life Style among the Magars

The study area has access to road even in rural villages; however, the roads are found raw and dusty. So there is easy access to modern machine produced foods, junk foods as well as foodstuffs and grains, fruits from Terai Madhesh, high altitudes, China and India. Sometimes, if there is a lack of desirable materials in the local market, they can order from Butwal, Pokhara, Kathmandu, even from abroad easily. Therefore, consumption of junk foods has been increased among the Magars. Instead, they lack appropriate awareness in nutrition and consumption which can lead to malnutrition.

In an earlier time, the Magars used to produce maize, rice, millet, beans and lentils, green vegetables, arum, potatoes, sweet potatoes, local fruits, nettle, cotton and so on for their livelihood. They kept buffalo, cow, goat, sheep, pig, chickens, duck and so on for milk products and meat. Their traditional foods were from local resources and based on organic production. They used to catch fish from the local stream and rivers. Similarly, they did hunting of deer, wild pheasant, birds and other wild animals for their food. They produced oil of mustard, *ārben/chiuri* and so on by the *Kolhu* (a wooden machine). They had traditional foods like *ānto* (corn rice), *chho* (rice), *beskām/beskāng* (bread form maize, millet, rice, wheat, buckwheat, barley, some kinds of yam and so on) *gānmet* (vegetable curry), *syāmet* (meat curry), *disyā* (fish curry), *bārā* (a kind dish made from the beans and lentil), *selbeskām* (made from rice flour cooking ghee), *biramālā* (made from lentil and beans), *chhop* (pickle).

Similarly, there used to be milk, ghee, *youghurt*, mahi, *ārben* (ingua-fruit) ghee and local products in local foods. The Magars ate pork, chicken, duck, fish, goat, sheep and wild birds and animals through hunting. However, they did not eat the meat of buffalo; but after the restoration of multiparty democracy, the Magars started eating beef due to the influence from others. The Magars used to prepare different kinds of wines from maize, rice, millet (from flour and grains); called *hure hān*, *chho-hān*, *hān*, *maddā*, *raksi* and so on. They also distilled the alcohol. They prepared the wine or alcohol from local wild fruits *ārben* (chiuri- ingua-fruit), *chutro* (barberry), *chibhwāng* (a kind of raspberry), *hade kāpha*, *kimbu* as well as

cultivated fruits like *satāk* (mango), *katahar* (jackfruit), *jhākatahar* (pineapple), *alubakhadā* (common apricot), *ghorli* (peach) and so on. The alcohol and wine-producing technique were based on indigenous knowledge and technology. Alcohol or wine-producing quantity was limited because there were limited sources of grains and fruits. Therefore, the use of alcohol and wine was limited being only used in feast and festivals, ceremonies and worships.

After developing connectivity of road, the grains were available easily as the local production was slightly increased and started to be commercialized. In contrast, the government and bureaucracy started to humiliate and discourage indigenous peoples' production. This is because, firstly, the political leaders or the relatives of bureaucracy opened alcohol factories; and secondly, there large amount of alcohol and wines as imported from abroad. And, there was a game of getting *PC* (percentage), and money for commission. So they did not have any interest to legalize local production and quality control, branding at the local level. Therefore, foreign branded alcohol beverages are easily available in the study area. Moreover, there were also cheapest alcohol and wines are available in the market. These varieties of alcoholic beverages attracted Magars and some misuses were also seen in the villages. The misuses by adolescences is hampering their education and learning new things. The misuse of alcohol is leading to increasing liver illness and other alcohol-related problems.

Furthermore, agriculture and animal husbandry works are decreasing in the villages; therefore, people depend in the market for all sorts of food items such as grains, fish, vegetables, beans and many more. In the market, organic foods are not available; therefore, several kinds of illnesses have been appearing among the Magars. On the other hand, the misuse of alcohol, use of junk food, overeating and low physical exercise altogether contributing in the increase of non-communicable illnesses like diabetes, hypertension, cancers and many more. Similarly, the culture serving milk, yoghurt, homemade wine or alcohol-based indigenous knowledge and technology to hospitality for the guests is substituted by the coca-cola, Pepsi, whisky, beer and other modern beverages. Similarly, the packed items are purchased from the market. Moreover, the cost of children education, family health care and other essential services have significantly increased. Hence the Magars are unable to save their money and invest in productive sectors of earning through foreign employment, *lāhuryā* profession, wage and so on. As a result, mental tension and illness have also occurred in the villages (based on the conversation with key informants).

CHAPTER SIX

HEALTH, SOCIO-ECONOMIC AND LIVELIHOOD OF MAGARS

The chapter deals with the description of the health care system and facilities of Nepal, socio-economic status of the Magars, livelihood, indigenous knowledge and skills, and so on. As being indigenous peoples, these are directly or indirectly related to health, illness and healing practices.

6.1 Health Care System and Facilities

This section deals health care system, facilities, policies of Nepal and available health care system. It provides directly or indirectly influence in health care facilities of local level where the Magars have been living, and construction of their ideas in health, illness and medication behaviours.

6.1.1 Introduction

Health care system of the ancient, medieval period of Nepal is unknown yet. However, some hints were found that Nepal had a good practice of health care in the past. In the Vedic period, *Kirant* virgins collected medicinal herbs in the Nepalese Himalayan area. *Kalidasa* also mentioned the medicinal plant and herbs found in Himalaya (Gartoulla, 1998, p. 70). Similarly, Dixit (2005) has mentioned "from the *Ramayana* one learns that Hanuman was asked to bring the *Sanjeevani Buti* from the mountains in the Himalayas" (p.1). Further, he stated that "Without arguing whether the actual mountain transported to Lanka was from India or Nepal one can say that many herbal medicines were in use then in these lands" (Dixit, 2005, p.1). Similarly, Buddha's five essential qualities that a person attending to the sick and *vinaya* or disciplinary for a monk to guide healthy living. Furthermore, "Buddha's disciple, King Ashok is credited to having established charitable hospital for both men and animal" (p.1). This indicates, "the history of medicine in Nepal may be considered to be fairly long" (Dixit, 2005, p.1). Likewise, the kings Ansu Barma (605-620 AD) and Pratap Malla's (1641-1674) period, there was a record of establishing Ayurvedic Hospital in Nepal (Dixit, 2005, p.2). In addition, Nepal had traditional health care systems in contemporary society. Modern bio-medicine was introduced by Christian Missionaries about 1740 AD in Nepal, but it was not spread out all over the country till the political changes in 1950s. After this political change, Allopathic medicine sprung and spread out all over the country. Later on,

the government also planned systematic developments in five years plan and its subsequent five years plan of the country. Furthermore, the constitution of Nepal, legislations and health policies are guiding health care setting of Nepal through the Ministry of Health and Population, and Department of health services to national level to local level.

6.1.2 Health Care Provision in Constitution of Nepal

Nepalese constitution 2015 (2072 BS) is the latest constitution of the nation. The constitution has provided an arrangement of right to live with dignity in article 16, which is essential to be healthy for a person and personal dignity could give head rise in the society to the respected person and give moral and empower to become healthy. Article 35 is related to 'rights relating to health'. Furthermore, article 30, 'Right to clean environment', article 36 'right to food', article 38 'rights of women' article 39, 'Right of the Child' are the related to health care. Similarly, article 51 has mentioned the 'policies of the state' and in sub-article 51 (h) has stated the "Policies relating to basic needs of the citizens and sub-article 51 (h) (5-10 and 15) are talking about related with health care. The constitution also divided the role of health care service level of local government, state government and the federal government. The detail is presented in Annex-IV.

6.1.3 Health Policy of Nepal

The government of Nepal has passed 'Rashtriya Swasthaya Niti-2071 BS' (National Health Policy) and revoked National Health Policy- 2048 BS) which is published in Annual Report 2071/72 (2014/2015) of GoN, MoH, Department of Health Services (DoHS). In the national health policy-2071BS has described article 5.1 vision, article 5.2 mission, article 5.3 stated goal of national health policy and article 6 has stated policies in of the national health policy-2071BS which are divided into sub-article 6(1)– 6(14). The detail is presented in Annex-V.

6.1.4 Human Development Index (HDI)

The HDI was created to emphasize that people and their capabilities should be the ultimate criteria for assessing the development of a country, not economic growth alone. The Human Development Index (HDI) is a summary measure of average achievement in key dimensions of human development: a long and healthy life, being knowledgeable and have a decent standard of living. The HDI is the geometric mean of normalized indices for each of the three dimensions. The health dimension is assessed by life expectancy at birth, the education dimension is measured by mean of years of schooling for adults aged 25 years and more and expected years of schooling for children of school entering age. The standard of living dimension is measured by gross national income per capita. The HDI simplifies and captures

only part of what human development entails. It does not reflect on inequalities, poverty, human security, empowerment, etc. The HDRO (Human Development Report Office) offers the other composite indices as a broader proxy on some of the key issues of human development, inequality, gender disparity and poverty (<http://hdr.undp.org/en/content/human-development-index-hdi>; visited date 26 Jan 2020).

Nepal's HDI value for 2018 is 0.579 which put the country in the medium human development category and rank positioning it at 147 out of 189 countries and territories of the world. Nepal's progress in each of the HDI indicators is presented as follows:

Table 6.1: Nepal's HDI Trends Based on Consistent Time Series Data and New Goalposts

Year	Life expectancy at birth	Expected years of schooling	Mean years of schooling	GNI per capita (2011 PPP\$)	HDI value
1990	54.4	7.5	2.0	1,192	0.380
1995	58.6	8.1	2.2	1,342	0.411
2000	62.3	9.0	2.4	1,532	0.446
2005	65.3	9.6	2.8	1,682	0.474
2010	67.6	12.0	3.3	2,002	0.527
2015	69.5	12.2	4.7	2,496	0.568
2016	69.8	12.2	4.9	2,486	0.572
2017	70.2	12.2	4.7	2,639	0.574
2018	70.5	12.2	4.9	2,748	0.579

Source:- http://hdr.undp.org/sites/all/themes/hdr_theme/country-notes/NPL.pdf, visited on 26 Jan 2020.

Between 1990 and 2018, Nepal's HDI value has increased from 0.380 to 0.579 and in percentage inclined of 52.6%. Between 1990 and 2018, Nepal's life expectancy at birth increased by 16.1 years, mean years of schooling went up by 2.8 years and expected years of schooling rose by 4.7 years. Nepal's GNI (Gross National Income) per capita had an incline by about 130.5 percent between 1990 and 2018.

In addition, the health outcomes in HDI of Nepal are in a medium level in overall the world. Nepal has done public health expenditure is 2.3% of GDP (Gross Domestic Product) and the country has physician (Doctors) 2.1 per 10,000 people. Similarly, life expectancy at age 60 is 17.3 Years. The HIV prevalence among adults (ages 15-49 years) is 0.2%. Infant exclusively breastfeeding practice is 56.9% in the age of 0-5 months of birth. The HDI reports show the there are lacking Infants from immunization (% of one year old) DPT is 6% and Measles 12% of one year old. Similarly, the child malnutrition situation of stunning moderate or severe was (% under 5years) 37.4% of under 5 years children. Nepal has an infant mortality

rate of 29.4 in 1000 live births and child mortality (under 5 years) 35.8 in 1000 live births. In such a way female mortality rate has 139 in 1000 adult people and male mortality has 177 in 1000 people of adults. Furthermore, the number of deaths due to Malaria was 0.2 and tuberculosis has 17 per 100,000 people (UNDP, 2016, p.228).

6.1.5 Millennium Development Goals and Sustainable Development Goals

Nepal is a member of the United Nations, therefore, the declaration of the UN also needed to adopt in making health policies within the country. The UN did the *Earth Summit* in June 1992 in Rio de Janeiro, Brazil and more than 178 countries adopted Agenda-21, a comprehensive plan of action to build a global partnership for sustainable development to improve human lives and protect the environment (Source: <https://sustainabledevelopment.un.org/?menu=1300>). After this UN declared the MDGs in 2000AD and SDGs in 2015 AD. The United Nations Millennium Development Goals were eight goals which had established by millennium submit in September 2000 AD of all 191 UN member states have agreed to try to achieve by the year 2015. The United Nations Millennium Declaration commits world leaders to combat poverty, hunger, disease, illiteracy, environmental degradation, and discrimination against women. The MDGs are derived from this Declaration, and all have specific targets and indicators. The Eight Millennium Development Goals were: (1) to eradicate extreme poverty and hunger; (2) to achieve universal primary education; (3) to promote gender equality and empower women; (4) to reduce child mortality; (5) to improve maternal health; (6) to combat HIV/AIDS, malaria, and other diseases; (7) to ensure environmental sustainability; and (8) to develop a global partnership for development.

The MDGs were inter-dependent; all the MDG influence health, and health influences all the MDGs. For example, better health enables children to learn and adults to earn. Gender equality was essential to the achievement of better health. Reducing poverty, hunger and environmental degradation positively influences, but also depended on, better health (Source: https://www.who.int/topics/millennium_development_goals/about/en/). As Nepal MDGs Progress Report 2013 points out, the Government of Nepal's commitment to achieving the MDGs, coupled with required policy reforms has borne fruit. Nepal is on track and is likely to achieve most of its MDG targets. The table of Annex-VI portrayed the achievements.

Furthermore, after the completion of MDGs, the UN General Assembly began the negotiation process on the post-2015 development agenda in January 2015. The process

culminated in the subsequent adoption of the 2030 Agenda for Sustainable development with 17 SDGs at its Core, at the UN Sustainable Development Summit in September 2015. The Sustainable Development Goals are: (1) No Poverty, (2) Zero Hunger, (3) Good Health and Well-being, (4) Quality Education, (5) Gender Equality, (6) Clean Water and Sanitation, (7) Affordable and Clean Energy, (8) Decent Work and Economic Growth, (9) Industry, Innovation, and Infrastructure, (10) Reducing Inequality, (11) Sustainable Cities and Communities, (12) Responsible Consumption and Production, (13) Climate Action, (14) Life Below Water, (15) Life On Land, (16) Peace, Justice, and Strong Institutions, and (17) Partnerships for the Goals. The goals are broad-based and interdependent. The 17 sustainable development goals each have a list of targets which are measured with indicators (Source: <https://sustainabledevelopment.un.org/?menu=1300>).

The health care system, development and prosperity process of Nepal have been influenced through the UN declarations. Before 2015, there were MDGs; and currently, SDGs to implement health care services.

6.1.6 Institutional Provisions

The government of Nepal arranges the funding for health care services and health care system. The parliament constructs and releases appropriate acts, laws, rules and regulations, and Judiciary system judge the justice of health care system and the supreme-court interprets the health-related acts, laws, rules and regulations according to the constitution. To conduct the health care system, the Government has the Ministry of Health and Population, Departments, autonomous bodies, professional councils, etc.

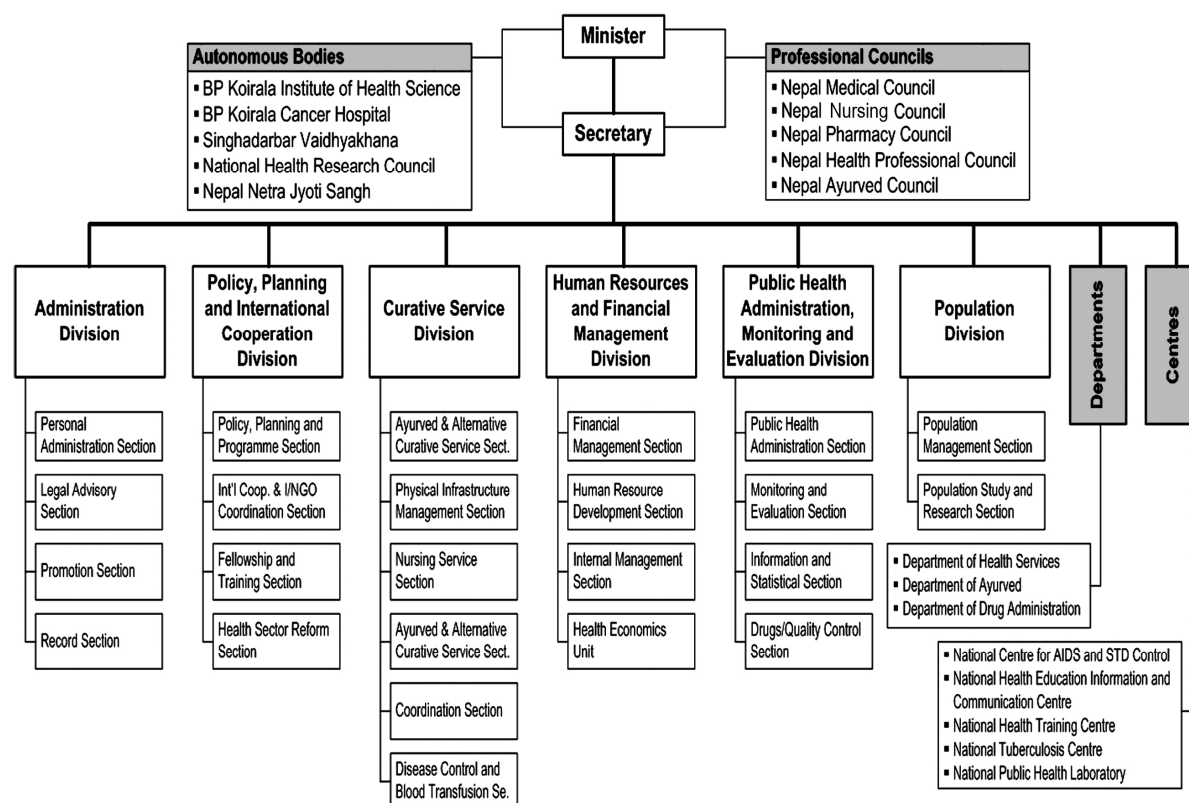
(a) Ministry of Health and Population

In Nepal, to conduct health care system, there is a Ministry of Health and Population in the top-level institution. The Ministry provides the leadership of autonomous bodies, professional councils, departments, divisions and centers. The organogram of the ministry of health and population is presented in figure No 6.1.4.1:

The organogram of the Ministry of Health and Population shows, Autonomous bodies include BP Koirala Institute of Health Sciences, Dharan, BP Koirala Cancer Hospital, Chitwan; Sinhadarbar Vaidhyakhana, National Health Research Council, Nepal Netra Jyoti Sangh which provide health care services. In Nepal, there are Nepal Medical Council, Nepal Nursing Council, Nepal Pharmacy Council, Nepal Health Profession Council, Nepal Ayurved Council, all known as professional councils. The professional councils are

responsible to enter the qualified man-powers in health care system, maintain and regulate ethics, quality control in medical and health professional education. In ministry, there are Administration Division, Policy, Planning and International Cooperation Division, Curative Service Division, Human Resources and Financial Management Division, Public Health Administration, Monitoring and Evaluation Division, Population Division for conducting the health care system. There is also the Department of Health Services, Department of Ayurved, and Department of Drug Administration. The department of health services leads regional health directories, Central Hospitals, Zonal Hospitals, district hospitals and district health care systems. The department of drug administration regulates the pharmacy and drug services and quality control in drug production, imports and in the market.

Figure 6.1: Organogram of Ministry of Health and Populations



Source: <http://www.mo hp.gov.np/content/organogram> (Access date 05 Aug 2018).

There is National Center for AIDS and STD Control, National Health Education Information and Communication Centre, National Health Training Centre, National Tuberculosis Center, National Public Health Laboratory under the Ministry of Health and Population. The National Health Training Center provides the trainings for the governmental health personnel and

develops human resources at a periodic level and refresher level. The centers are responsible to provide health care services according to their nature.

(b) Department of Health Services (DoHS)

To conduct the health care system in the country, there is a department of health services at central level under the Ministry of Health and Population. Department of Health Services (DoHS) is responsible for delivering preventive, promotive, diagnostic and curative health services throughout Nepal. Director General (DG) is the organisational head of the DoHS. The current organizational structure of the DoHS includes six Divisions: (1) Management Division with infrastructure, planning, quality of care, management information system and free medication & treatment for very severe disease to impoverished Nepalese citizens. (2) Child Health Division covering EPI, Nutrition and CB-IMCI and Newborn care. (3) Family Health Division with the responsibility of reproductive health care, including safe motherhood and neonatal health, family planning and Female Community Health Volunteers (FCHVs). (4) Logistics Management Division covers procurement, supplies and management of logistics, equipment and services required by DoHS and below level (5) Epidemiology and Disease Control Division with the responsibility of controlling epidemics, pandemic and endemic diseases as well as treatment of animal bites. (6) Primary Health Care Revitalization Division with the responsibility of carrying out activities for primary health care (DoHS, 2015 p. 2). The organogram of the Department of Health Services and its major functions are presented in Annex-VII:

(c) Regional Health Directorates (RHDs)

The Annex-V shows that at the regional level there are five Regional Health Directorates (RHDs) providing technical backstopping as well as program monitoring to the districts. The RHDs are directly under the MoHP. There are regional, sub-regional and zonal hospitals, which have been given decentralized authority through the formation of Hospital Development Boards. In addition, there are training centres, laboratories, TB centres (in some regions) and medical stores at the regional level (DoHS, 2015 p.3).

(d) District Health Office (DHO)

At the district level, the structure varies between districts. Fifty-nine districts are managed by the District Health Office (DHO) whereas the remaining sixteen are managed solely by the District Public Health Office (DPHO). The DPHOs and DHOs are responsible for implementing essential health care services (EHCS) and monitor activities and outputs of District Hospitals, Primary Health Care Centres (PHCCs), Health Posts (HPs) and Sub Health Posts (SHPs) (DoHS, 2015 p.4).

A sub-health post is the first institutional contact point for basic health services. SHPs monitor the activities of FCHVs as well as community-based activities by PHC outreach clinics and EPI clinics. Besides, SHP also functions as the referral centre of FCHVs as well as a venue for community-based activities such as PHC/ORC and EPI clinics. The health post offers the same package of SHPs plus birthing centres in the respective VDC. Each level above the SHP is a referral point in a network from SHP to Health Post (HP) to Primary Health Care Centre (PHCC), on to district, zonal sub-regional and regional hospitals, and finally to tertiary level hospitals. This referral hierarchy has been designed to ensure that the majority of the population receive public health and minor treatment in places accessible to them and at a price they can afford. Inversely, the system works as a supporting mechanism for lower levels by providing logistical, financial, supervisory, and technical support from the centre to the periphery (DoHS, 2015 p.4).

6.1.7 Medical Colleges and Teaching Hospitals

Medical Colleges and Teaching Hospitals are also providing health care facilities in Nepal and producing qualified man-powers. In Nepal, currently, there are 19 Medical colleges and teaching hospitals that produce medical doctors, nurses and other qualified medical and health profession-related graduate man-power (See Annex-VIII). Among the 19 Medical Colleges and Teaching Hospitals, four are public, one army medical college and remainders 14 are from the private sector. The seven medical colleges are within the Kathmandu valley and remainders are out of the Kathmandu valley, in the big-city areas.

In spite of that, CTEVT also conducting and CTEVT affiliated colleges also producing Medical and Health man-powers, such as CMA, HA, ANM, Staff Nurse, Lab Assistant, Lab Technologist, Radiographer, Physiotherapist, Ayurved (Baidhya, Kabiraj), etc. Those CTEVT affiliated colleges who are running certificate level Nursing, General Medicine and other courses should have at least 50 bedded hospital and most of them running as private hospital and community hospital. Similarly, Kathmandu University, Pokhara University, Purbanchal University and other universities also running the program of Undergraduate and

Graduate courses in Nursing, Public Health, Pharmacy, Physiotherapy and many more subjects to produce manpower and running hospital to provide health care from the private sector and university themselves. In such a way, Tribhuvan University and Nepal Sanskrit University are also conducting Undergraduate and graduate courses in Ayurvedic Medicine.

6.1.8 Private Hospitals

In Nepal, private sectors also have a major contribution in health care system and they are providing medical services to the Nepalese people. However, private medical institutions have their own categories according to their infrastructure, quality of service and qualified manpower. It may be sometimes debateable in society, however, social stratification and differentiation also dictate the service receiving and providing of health care services. Some private hospitals are also running from NGOs, CBOs, local community, co-operatives and called community hospitals. The distribution of the private hospitals in Nepal is presented in table 6.2:

Table 6.2: Distribution of Private Hospital in Nepal

S.N.	Development Region	Hospital Type					Bed Category				
		Private	Community	Other	Total	%	Up to 15 Beds	16 to 50 Beds	51 to 100 Beds	100 Beds and Above	Total
Development Region											
1	Eastern	47	10	11	68	22.59	50	9	7	2	68
2	Central	103	24	16	143	47.51	60	32	37	14	143
3	Western	40	14	5	59	19.60	23	17	12	7	59
4	Mid western	17	3	1	21	6.98	14	2	3	2	21
5	Far Western	7	3	0	10	3.32	3	5	2	0	10
Ecological Belt											
1	Mountain	6	2	1	9	2.99	6	2	1	0	9
2	Hill	102	30	16	148	49.17	62	37	36	13	148
3	Terai	106	22	16	144	47.84	82	26	24	12	144
Out of and In Kathmandu Valley											
1	Kathmandu Valley	49	11	7	67	22.26	15	20	25	7	67
2	Out of Kathmandu Valley	165	43	26	234	77.74	135	45	36	18	234
Date of Hospital Operation											
1	Operated in 2046 BS and Before	5	5	6	16	5.32	1	6	3	6	16
2	Operated from 2047 to 2062 BS	64	21	10	95	31.56	25	31	25	14	95

3	Operated in 2063 BS and After	145	28	17	190	63.12	124	28	33	5	190
	NEPAL	214	54	33	301	100	150	65	61	25	301

Source: CBS, 2013, P. (A Report on Census of Private Hospitals in Nepal 2013).

The table 6.2 shows that there are 301 private hospitals in the country in CBS of 2013. Most of them are concentrated in the central region (47.51%) and Kathmandu Valley (22.26%) and low distribution in the far-western region (3.32%). The central region has bigger hospitals (100 beds and above) more than other regions. Terai and Hill distribution is not much vast difference but the Himalayan region has low distribution. More private, community hospitals were established and operated after 2063 BS revolution and political changes.

The contribution of the private sectors has the main portion and partner of health care services of Nepal. The pharmacy and drug service are handled by totally private sectors. The private sector in health care service is increasing in number day by day in Nepalese society. The Government has various institutions to monitor and evaluate the private sector, and provide direction for quality, effective and affordable health care services to the public, and punishment if found guilty. Effective monitoring and evaluations, encouragements, reward and punishment from the governed level could give assurance of the quality of the health care system in Nepal to the public health.

6.1.9 Health-related NGOs and INGOs

In Nepal, there are several NGOs and INGO that are supporting or direct working into the national health care system. The report of FY 2072/73 of Social Welfare Council of Nepal (Government agency), in Nepal there are 254 INGOs⁴ are working in the country. Similarly, several NGOs are working in Nepal. There are 39,763 NGOs⁵ registered in Social Welfare Council of Nepal. However, all NGOs are not functioning. There are approximately 6,000 NGOs recognized by the Government. It is estimated that more than 15,000 NGOs in Nepal are working in various sectors⁶. Ministry of Health and Population and Department of Health Services recognized INGO and NGOs who are directly supporting health care with the government. These are (1) CARE Nepal, (2) Child Welfare Scheme (CWSN), (3) Family Planning Association of Nepal, (4) Handicap International Nepal, (5) Helen Keller International, (6) International Nepal Fellowship (INF), (7) Ipas (International Pregnancy

⁴ Source: http://www.swc.org.np/wp-content/uploads/2016/03/List-of-INGOs-2072_073-Falgun-Masant.pdf (Download date 30 July 2018).

⁵ Source: http://www.swc.org.np/wp-content/uploads/2016/01/SWC_NGOs_2034_071-asadh_-Final-in-bhadra-2072.pdf (Download date 30 July 2018).

⁶ Source: http://www.visitnepal.com/nepal_information/ngo_in_nepal.php (Website visited date 30 July 2018)

Advisory Services), (8) Marie Stopes International (MSIN), (9) Medecins du Monde (Mdm), (10) Merlin Nepal, (11) Mesothelioma Center, (12) Micronutrient Initiative (MI), (13) Nepal Youth Foundation (NYF), (14) Netherlands Leprosy Relief (NLR), (15) Nick Simons Institute (NSI), (16) One Heart, (17) Plan Nepal, (18) Population Services International (PSI), (19) Save the Children, (20) The Britain-Nepal Medical Trust (BNMT), (21) United Mission to Nepal (UMN), (22) Water Aid, (23) World Neighbours, (24) World Vision International (Source: DoHS⁷).

The role of NGOs and INGOs in the health care service of Nepal has very much importance in rural health care, family planning, MCH care, Nutrition, Tuberculosis, Leprosy, Handicap health care, health education and promotion of health, curative and preventive sectors. There was also the establishment of Hospital and Health care centers from the INGOs such as United Mission to Nepal and other organizations (Dixit, 2005). The government of Nepal, the Ministry of Health and Population and its bodies monitor and evaluates, regulates the health programs conducted by the NGOs and INGOs. Sometimes, the media also cover the news of the NGOs and INGOs activities regarding Health care services.

6.1.10 Alternative Health Care Services In Nepal

(a) Ayurvedic Health Care Services: In Nepal, the Government has been providing health care services through Ayurvedic health care. The governmental Universities: TU and Nepal Sanskrit University have a graduate course in Ayurveda. The Naradevi Ayurvedic Hospital is the central hospital from the government (<http://www.nah.gov.np>) and most of the districts have Ayurvedic health institutions. Furthermore, Singh Durbar Vaidhyakhana produced Ayurvedic medicines from the Government level (<http://vaidyakhana.gov.np/>). In addition, there are several Ayurved hospitals and health institutions, Ayurvedic Pharmacies in cities or urban areas of Nepal from the private sector. There is an autonomous body to regulate and control Ayurvedic medicine is called Nepal Ayurvedic Medical Council (NAMC). It was established under the Ayurveda Medical Council Act, 2045 BS (<https://namc.org.np/>).

(b) Homeopathic Health Care Services: In Nepal, the Homeopathic system also popular with People. Homeopathy, or homeopathic medicine, is a holistic system of treatment that originated in the late 18th century, formally founded by a German physician, Samuel Hahnemann (1755–1843). The name ‘homeopathy’ is derived from two Greek words that mean ‘like disease’. Homeopathy is based on the idea that substances that produce symptoms of sickness in healthy people will have a curative effect when given in very dilute quantities

⁷ Source: <http://www.nhssp.org.np/non-government-organisations.html> (Website visited date: 30 July 2018).

to sick people who exhibit those same symptoms. The remedies are believed to stimulate the body's own healing processes (Source: <http://ecs.com.np/features/alternate-healing>, retrieved date 20 Jan 2020). There are several homeopathic hospitals and clinics, homeopathic pharmacies in the urban areas of Nepal from the private sector. And from the governmental sector one hospital named Pashupati Homeopathic Hospital, Hariharbhawan Lalitpur is providing service.

(c) Unani Medicine System: Unani-tibb or Unani Medicine is a form of traditional medicine practiced in Middle-East and South-Asian countries. It refers to a tradition of Graeco-Arabic medicine, which is based on the teachings of Greek physician Hippocrates and Roman physician Galen and developed into an elaborate medical system in the middle age era by Arabian and Persian physicians, such as Rhazes (al-Razi), Avicenna (Ibn-e- Sina), Al-Zahrawi, and Ibn Nafis. It originated in Greece almost 2500 years back, which is herbo- animo- mineral in origin (Approximately 90% herbal, 4-5% animal and 5-6 % mineral) (https://www.nhp.gov.in/unani-introduction_mtl, visited 20 Jan 2020).

(d) Acupuncture: Acupuncture is a form of alternative medicine. It has a key component of traditional Chinese medicine (TCM) in which thin needles are inserted into the body. The history of acupuncture in China dates back to many centuries BC when stone needles were used instead of today's finely manufactured stainless steel ones. The term acupuncture derives from the Latin *ocus*, meaning needle, and *pungere* meaning to puncture or penetrate. It is an external treatment for internal disorders (<http://ecs.com.np/features/alternate-healing>). In Nepal, there are several acupuncture clinics and health institutions from the private sector.

(e) Naturopathy: Naturopathy is a health practice that applies natural therapies. Her/his spectrum comprises far more than fasting, nutrition, water, and exercise; it includes approved natural healing practices such as Homeopathy, Acupuncture, and Herbal Medicine, as well as the use of modern methods like Bio-Resonance, Ozone-Therapy, and Colon Hydrotherapy. And, principles of Naturopathy were first used by the Hippocratic School of Medicine in about 400 BC (<https://www.naturopathy-uk.com/home/home-what-is-naturopathy/>). In Nepal, there are some private clinics in naturopathy (<http://ecs.com.np/features/alternate-healing>).

(f) Amchi: Amchi is also known as "Sowa-Rigpa". Amchi system of medicine is one of the oldest, living and well-documented medical traditions of the world. It has been popular practice in Tibet, Magnolia, Bhutan, some parts of China, Nepal, Himalayan regions of India and few parts of the former Soviet Union, etc. (<http://vikaspedia.in/health/ayush/sowa-rigpa>).

In Nepal, this alternative medicine is practiced in the Himalayan region. There is one Amchi school in Upper Mustang (Bista & Bista, 2005).

(g) Faith Healing and Ethno-medicines: Nepalese, traditional health care practicing system mostly connected with culture, religion, indigenous knowledge and society. There are several shrines, feast and festival which are connected with faith of well being and misfortune. Nepalese people have belief in shrines, their priests, religious and cultural feast and festival, religious fairs, supernatural powers and celebrate them, worship them for good health and well-being. There is practiced shamanism (*lama/Jhakri*), locally using herbs and shrubs for healing, ethnic medicine. The ethno-medicines vary according to location, geography and ethnic people. However, faith-healing and ethno-medicines are rooted in the Nepalese culture and society.

6.1.11 Nepal Health Research Council

Nepal government has an independent institution to regulate, promote and monitor the field of research in health issues, known as the Nepal Health Research Council (NHRC). The NHRC is formed in Nepal Health Research Council Act-2047(1991). The health research council provides national health research policies based on WHO provisions and national needs. Council also facilitates and promotes health research within the country. This institution also has the right to provide permission about the health research within Nepal and only one organization that monitors the health research issues, ethical issues in health and medical sector research.

6.2 Socio-economic Situation, Livelihood and Health among the Magars

In this section, the socio-economic situation of the Magars and their livelihood; changes through migration, climate changes, development of infrastructures and impacts on livelihood, dress and ornaments, food habits are discussed. The socio-economic status, changes in socio-economic situation and other social changes plays role in livelihood change of the community or society which is directly related to health, illness and medication practices.

6.2.1 Income Sources and Livelihood among Magars

The socio-economic activities, opportunities and consumption trends are associated with people and communities. The western scholars/writers Kirkpatrick (1811) and Hamilton (1818) collected information about the Magar as; skilled agriculturist, an expert on construction works (buildings, carpenter, mason, Bridge, etc.), an expert on mineral extract works and loyal warrior of Government of Nepal, strong labour forces about the occupation and livelihood. Similarly, Brian H. Hodgson (1874), Daniel Wright (1877), Oldfield, Hector Ambrose (1880), Levi Sylvain (2005), Eden Vansittart, (1906), and other writers have given emphasis on Brave Gurkha soldiers for Magars and other indigenous peoples of Nepal. Bista (2011), Hitchcock (1966), Sharma (2067 BS) and several Nepali scholars are repeating the mentioned information. Fisher (1985) found northern Magar's involvement in trade and agriculture for livelihood. Also before democracy (2007BS), the Magar villages were not connected with modernity, the modern health care system and westernization and they were survived through the indigenous healing system. Therefore, in that situation, the Magar culture, social beliefs towards health and illness were well constructed.

Before the construction of the Siddhartha Highway and Malaria eradication program in Terai/ Madhesh, the income source of Magars for livelihood were agriculture, animal husbandry, construction works (buildings, carpenter, mason, bridge, etc.), service in the British Indian Gurkha army, Nepal army/police services, labour works. The extracting minerals from ores were closed in Rana regime. They fetched salt from Thakkhola and Bhot, but around the ending time of *Rana* regime Indian salt was available on the border of India, then in Butwal. After the opening of Siddhartha Highway, the Malaria eradication program of Nepal, Democracy and connection with abroad for occupation, the sources of income and livelihood also changed among the Magars of the study area (based on the conversation with key informants).

The income source of the study area changed with road connectivity through Siddhartha Highway around the 1960s. The poor household's youths or those who could not join in Gurkha

army went to India for hunting jobs in the private sectors too. Restoration of the multiparty democracy (1990) opened foreign country employment, and abroad education. Then youths going to foreign countries for employment and education increased. Similarly, Hong Kong ID (settlement facilities in Hong Kong) opened for the British Gurkha ex-army and their families; so, several Magars migrated to Hong Kong. In addition, the people's war of Maoists pushed the youths to India or foreign countries due to insecurity from both sides (government forces and Maoist forces). The first choice of the Magar youths is to join in the British army, Singapore police and secondly, Indian army. And remaining the lower-middle class youths go to Malaysia and Gulf countries, higher-middle class youths to South Korea, European countries or developed and high-income countries. However, lower-class youths go to Indian cities to work. In recent years, females are also increasing in going foreign countries to work. The majority of peoples have left agriculture works; especially those who have outside income sources rather than agriculture, or remittance. For these households, doing agriculture is rhetoric. In real, agricultural production is degraded in the villages and many cultivated lands are barren and becoming useless (based on the conversation with key informants).

The economic sources of households which were found during the survey in the study area are presented in table 6.3:

Table 6.3: Income Sources of Household for Livelihood among the Magars of the Study Area

Income Source of Household	Sex of Respondent				Total	
	Female		Male			
	f	%	f	%	f	%
Agriculture	32	5.0	43	6.8	75	11.8
Agriculture, Labour or Wage's works, Skill works	12	1.9	23	3.6	35	5.5
Agriculture, Private Job in India or Equivalence	39	6.1	29	4.6	68	10.7
Agriculture, Business/ Small Entrepreneurships	12	1.9	16	2.5	28	4.4
Agriculture, Service/ Jobs in other Sectors	15	2.4	5	0.8	20	3.1
Agriculture, Teacher/Nepal Army/Police/Govt. Job/Pension	24	3.8	31	4.9	55	8.6
Other Sources not including Agriculture (e.g. Job, Foreign Employment, Business etc)	28	4.4	14	2.2	42	6.6
Agriculture, Foreign Employment (Gulf, Malaysia or Equivalent)	66	10.4	59	9.3	125	19.7
Agriculture, Indian Army/Police or Pension	78	12.3	83	13.1	161	25.3
Agriculture, Foreign Employment (Korea, Afghanistan, Iraq, Europe, America or Equivalent)	8	1.3	12	1.9	20	3.1
Agriculture, British Army/Singapore Police or Pensioner	4	0.6	3	0.5	7	1.1
Total	318	50.0	318	50.0	636	100.0

Source: Field Survey 2015.

The table 6.3 shows that, majority of respondents households (Agriculture with Private Job in India or equivalence 10.7%, Agriculture with Indian Army/police or Pension 25.3%, Agriculture with Foreign employment (Gulf, Malaysia or equivalent) 19.7%, Agriculture with Foreign Employment (Korea, Afghanistan, Iraq, Europe, America or equivalent) 3.1%, Agriculture with British Army/ Singapore Police or Pensioner 1.1%, Other sources not including Agriculture (e.g. Job, foreign employment, Business, etc) 6.6%. In aggregate 66.5% were found income source of foreign employment including India. The households having income source Agriculture only was 11.8% and having income source of household within the country was lower percentage in the study area. Furthermore, key informants were told, many Magar households who had an economic situation better they were migrated towards Terai/Madhesh and city area for better livelihood.

6.2.2 Migration and Health among the Magars

In the study area, migration is high for seeking jobs and a better life to an urban area, Madhesh, India and foreign countries. It is considered that Nepalese started migration for jobs to Lahore (current Pakistan) after the Anglo-Nepalese war (1814-16) in military service by the warrior Bhakti Thapa. The *British's East India Company* gathered Nepalese warriors and they form Gurkha regiments (GRs) after the *Sugauli Treaty* of 04 March 1816 (<https://www.britannica.com/event/Treaty-of-Sagauli>). Then the migrations to work into Gurkha soldier in foreign country started massively. The Magars were the major portion in British India Gurkha regiments of British Empire, and after the independence of India; Indian Gorkha Regiments and British Gurkha Regiments including Singapore police regiments.

In 2001, the population of the Syangja district was 317,320 and which was decreased to 289,148 in 2011 census. Similarly, Magar population was 67,245 on 2001 CBS and in CBS 2011, it decreased at 62,074 (CBS 2011 & CBS 2001). The decreasing population of the district and Magars is due to migration towards Terai/Madhesh and city area, and as well as foreign employment including India.

In the study area, there was high prestige and pride in joining British Gurkha Regiments, Singapore Police regiments, Indian Gorkha regiments among the Magars. Magar youths who fall in unable to join army job, they had trends to go foreign countries to earn money and subsistence of livelihood. In general, families having higher income sources aims to go Europe, America, Japan and other developed countries or more earning countries. The families having middle-income sources aims to go to gulf countries and Malaysia or equivalent countries, and families having lower income source or below poverty level, they

go to Indian cities. The Magars called *Lāhure* or *Lāhuryā* for foreign employees; but they categorize different stratification according to the nature of job and income. The Majority of Magar families have *Lāhuryās* to subsistence family livelihood. So, in the village majority population living are senior citizens, children and housewives. Nowadays female *Lāhuryā* are also increasing in the villages. This *Lāhuryā* system is making their family members dependent and lazy in agriculture works, therefore, the barren land is increasing in place of agricultural field in the villages. Furthermore, the *Lāhuryā* families having good income are migrating towards urban areas/cities or road-heads.

Due to remittance, there is also a trend of migration of spouses of *Lāhuryā* (or *Lāhureni*) towards road-head markets or cities leaving old father-in-law (Nibā) and mothers-in-law (Nimā) in the village, in the name of better education for their children. Therefore, students are decreasing in village schools. On the other hand, in road-head markets and cities have increased behaviour deviations (disorders) due to freedom without responsibility and remittance money. So, there are problems such as family disputes, separation between husband and wife, conflict within household and divorce, elopements, low progress in children education and awareness, misuse of drugs and alcohol in the Magar society. These consequences are leading to mental health problems, communicable illnesses and other illnesses. On the other hand, the migrant workers could have imported communicable illness including HIV/AIDS, STI and new illnesses like COVID-19 and so on. Most of the migrated labours from the Magar communities have low-level awareness, or some have semi-educated, so there is a risk of importing illness in the family. Likewise, most of them get into dirty, danger and double-duty (3D) works. There is also a chance to be contacted with prostitutes and multiple partners which adds health risks.

On the other side, the wives who have left the villages due to their husbands' foreign employment are found engaged in making multi-partners and excessive expenditure. This leads to issues or problems to families, children's education, and lack of saving money or property. In addition, they have not any idea about income generations, saving and investments. So, consumerism has been increased among the Magars and unnecessary expenditure on food, fashion and dress, gazettes and recreational goods. Furthermore, due to remittance, people are becoming lazy and dependent; and they have left ancestral works of agriculture, construction or engineering. This leads to lack of physical exercise, instead, overeating has been increased. Such behaviors have increasing chances of heart illness, diabetes, liver illness, kidney illness, cancer and so on. From these facts; there were also

increasing mental illness as well as communicable illness and other illness (based on the conversation with key informants).

6.2.3 Climate Change and Health among the Magars

Climate change and global warming are the burning issues in the world. Climate change has been added new illnesses and health problems. The Magars had understood climate change as spreading mosquitoes in high altitude area of cold climates/ mountains of Magar habitats and emerging new illness, changing raining pattern and affecting crops production, diseases in crops, increasing insects and damaging cultivations, droughts and dryness of water resources even increasing greenery forest in the hills, decreasing fishes in the stream and rivers, feeling of increasing hot weather and so on.

Furthermore, the key informants of the study area were told climate changes leading to a decrease in the production and failing indigenous knowledge in the production of crops and livelihood. The indigenous cultivation of crops and animal husbandry yields low production. This also adds extra burden and compels them to become *Lāhuryā* and fade off the agricultural field. Sometimes climate changes result in heavy rain which causes landslides and floods in the villages and cultivated land. These consequences are also pushing factors to become *Lāhuryā* and migrations which have an impact on livelihood, culture and languages of the Magars. Moreover, climate changes have brought new illnesses to the Magar settlements (based on the conversation with key informants).

6.2.4 Development of Facilities and Health among the Magars

The development of villages is playing role in increasing facilities and services in the rural areas. It is also adding new socio-economic opportunities to the Magars. Development of infrastructures is making life easier in the villages and easy access to health care services and hospitals, education and fulfilment of other needs of human beings. In the Magar villages, the development of infrastructure has been increasing fast, and it has added more facilities such as education, health facilities, communication and information (ICT), entertainment from media or television, and connectivity with other peoples. However, in development process, the government and development agencies have not shown good intention in safeguarding local indigenous peoples' language, culture, local knowledge and skills including local, social and natural environment. There is a lack of indigenous cultural impact assessment, indigenous language impact assessment and mitigation plans, resettlements and safeguards in the development of education, media and ICT, health care facilities, bureaucratic and political development, social development programs, infrastructure developments such as road and

connectivity, hydro-electricity and so on. This attitude is leading to disappearing intangible heritages (such as Magar language, culture, social norms and values, belief systems, indigenous knowledge and skills). For example, in educational developments, the government can use multicultural and multilingual teaching methods in primary schools, and one subject of the Magar language and culture can be taught in school to safeguard the Magar language and their culture.

The social deviation, cultural changes were appearing in the Magar villages due to haphazard developments. The cost of using facilities is also adding the economic burden in livelihood; the consequence is leading to become *Lāhuryā* and dependency. The radios, televisions and media of Nepal and neighbouring country and schooling system have major roles in creating a deviation in ancestral culture and language for and of the Magars. So, new generation and educated persons are hesitating in adopting Magar culture and speaking Magar languages rather they are changing their ancestral religion and customs. The misuse of telephone, Facebook (social media), internet and means of communication and information leading to deviation in family life, conflict in the family, suffering from exploitation, elopement and divorces, child marriages, substance use and alcohol misuse, and so on.

Furthermore, infrastructure development has brought consumption of luxurious goods, sophisticated life, emitting copy cat of wealthy peoples or as shown on television or films which is leading a dependency. This is also leading to a decline in saving and making capital for investment and expenditure in sophisticate. Such types of behaviours seen in the Magar society can result in mental disorders, communicable illnesses including HIV/AIDS, non-communicable illnesses such as hypertension, heart diseases, chronic kidney failure, diabetes, cancers, etc. (based on the conversation with key informants).

6.3 Indigenous Knowledge Related Health, Illness and Healings

The Magars have their own indigenous knowledge and skills (IKS) about health, illness, medication, well-being and public health which are preserved in their language. These indigenous knowledge and skills have been transferring from one generation to the next generation orally. This IKs is in danger because this is not included in the national mainstream education system and degradation of Magar as their mother tongue. Language is a part of the culture. The local language plays a great role in the understanding of health, illness and healings of the disease in socio-cultural context. Local people construct their own ideas about illness, health and medication according to their language, culture and society (Helman 2007; Cockerham 2012). In medical sociology and medical anthropology, it is also discussed about the lay concept of illness, sickness and disease constructed from the community. In this chapter, I have discussed indigenous knowledge and listed nomenclature of ill-health and healings among the Magars based on the conversation with key informants, observation and focus group discussions.

6.3.1 Traditional Health Care Practices among the Magars

It is difficult to explore the traditional health care practices among the Magars because they lack a written system or documents. On the other hand, there was a custom of burning all creations, books and arts with a deceased person in a cremation ritual. Therefore, although there might have written evidence, they all were burned or buried with the deceased person. The left knowledge among the Magars is the only oral transmission and existed in oral form. Today, the Magars are adopting medical pluralism from the market. Indigenously, they collect local medicinal herbs and shrubs that they have the knowledge and use when they become ill. Those herbs and shrubs are being used from immemorial time, and this knowledge is being transferred through oral tradition. The Magars are practicing their own indigenous medical healings (ethno-medicine) such as using locally available medicinal plants and substances, *lāmā/ wārcha bharmi*, faith healings through folk dances and songs (e.g. Ghānto), worshiping nature for well beings and health, illness defining in their own language and so on. However, ethno-medicine practice is decreasing due to the popularity of bio-medicine. The governmental health care system has discouraged ethno-medicine, shamanism and traditional health care. In the study area, the traditional shamanism, folk healings (faith healings) practices are transferring to *Sachchai Abhiyan* of Christian missionaries, Church and so on. It also looks like new shamanism from Christian belief and

local variant. The traditional shamanisms are replaced by Christian shaman, Hindu Mata and other forms where Magar culture can be reflected.

The traditional healer in the Magars villages is *lama* /lama/. The meaning of *lam* /lam/ in Magar language is path, way or road and *lama* means path shower or philosopher or who knows everything (having doctorate knowledge). Therefore, *lama* has an excellent prestige in the Magar society. The allopathic medicine spread out after the political changes of the 1950s into village level. In the study area, it spread out after 1970/80s, and recently medicine shops are available in the majority of Magar villages. Before allopathic publicity in the study area, the main healers were *lāmā* or *wārch bharmi* (shaman). The traditional healers had no systematic education, laboratory test and modern equipment, chemically analyzed local medicines and treatment centers. So, western medicine captured their market easily. Generally, *lāmā* knows nomenclatures of the illness, locally available medicinal objects and dosages, use of herbs and shrubs or medicinal plants, causes of illness, faith healings and so on. These were transformed from generation to generation in oral form in their own culture and language. The different view of key informants was such as 'the *lāmā* had books and they studied such they also wrote books. However, when he died, then their all creation and books were buried or burned with corps because there was a rumour that the dead person will get it in heaven. The idea was provided by Hindu priests⁸. In such a way Christian missionaries are saying the same thing as the Hindu priests did in the Magar society⁹. Therefore, indigenous knowledge has been swept away with the death of *lamas* and Magars. So the Magars remained vacant without their own philosophy.

Another health practice in the Magar villages is faith healing. This type of healing is better for mentally ill, mentally weak and frustrated persons. Among the Magars, faith healing is taking as culture and tradition. The folk lyrical drama *ghantu* /g^hantu/ or *ghanto* /g^hanto/ is based on faith healings. In the study area, if someone falls in illness, or prolonged in healing although using *allopathy* medicine or disease could not be diagnosed, then they used to perform and take part in *ghantu* folk dance. Generally, young girls take part in dance and they do not have any restrictions to marriage when taking part in the dance. After marriage, they can continue *ghantu* dance. If a family member or girl falls in ill-health, then they usually go

⁸ Conversation with Kansiram Thapa, age 75 of Chandibhanjyang, Ghurdanda on 22/12/2071BS and Innisara Gaha, age 84 of Birgha VDC Waigha on 25/12/2077.

⁹ Conversation with Wum Maya Thapa, age 43 of Krishnagandaki VDC Balam on 06/01/2077 and Rishiram Rana age 43 of Alamdevi VDC lasarghabeshi.

to *lama*. Sometimes if it is not cured from *allopathy*, after that, they go to *lama*. Then he (*lama*) sends to dance *ghantu* according to his judgment of ill-health.

Moreover, a belief in the *lagobhago*, witch, ghost and worship of local god, goddess, natural objects and so on are also faith healings in the Magar Society. *Dhami* and *Jhankri* words are derived from the Khas-Nepali language for the shaman. But, in the Magar villages, the word *lama* is used, and *rama* /*rama*/ in Rukum and Rolpa. They have their own philosophy and healing system in oral or unwritten form. Similarly, fortune tellers or *jaisi* (astrologers), priests of local shrines are also faith healers in the study area. However, in recent years, the culture of local shrines is changed into pure Indian Hindu culture. So, an Indian god's idol is erected in the shrine weaving new stories according to Indian Hindu myth. Before some decades, it was not the tradition of keeping an idol or statue of Indian gods at the local Shrines and *Kot (Jong)s* of the Magar ancestors. Later on, slowly, new stories were created about the shrines, idols got erected which displaced Magar culture, indigenous knowledge and beliefs. Due to this fact, they were left with not philosophy. As a result, they got attracted to new religions. Along with several changes that have occurred in the society, political situation, education system, mass media and communication system, publicity of bio-medicine; the traditional health care practices among the Magars are also rapidly changing before being documented (based on the conversation with key informants, focus group discussions).

6.3.2 Some IKs regarding Health and Wellbeing Preserved in Mother Tongue

The indigenous knowledge toward ill-health, medication practices are based on their ancestral mother tongue and culture. The classification of illness, perception of health care and public health, epidemiology of illness, understanding body and body parts (Anatomy and physiology), preventive measures and healings and other aspects of traditional health care or ethno-medicine are reflected in their own language.

About the indigenous knowledge in the Magar language, the medicinal plants such as *titepāti* (wormwood/mugwort), *gherenā* (a kind of medicinal plant) and so on are frequently used in Magar ritual cultures and worships. The senior and elderly Magars know *thoksing* /*tʰoksiŋ*/, *gwaangling* /*gwanliŋ*/, *ghormet* /*gʰormet*/, *gwasyaasing* /*gwʌsjaŋsiŋ*/, *kaaphal* /*kapʰʌl*/, *pharedo* /*pʰʌredo*/, *raini* /*rʌjni*/, *jukryaak* /*dʒukrjak*/, *thikan thyaap* /*tʰikʌn tʰjap*/, *muruk* /*muruk*/, *pataksar* /*pʌtaksar*/, *hadam* /*hʌdam*/, *pati* or *khacha pati* /*pati*, *kʰa tʃpati*/, *gherena* /*gʰerena*/ etc. and they use such medicinal plants for healing. However, the new and younger generation found forgetting these indigenous medicinal plants and curing systems.

The Magars also have indigenous nomenclatures in healing and illness e.g. sikhan/sik^hΛn/, jabe /dʒΛbe/, ukuj /ukudʒ/, taahaan/tahan/ or taanhaan /tan^han/, mhaan /m^han/, karhaan-mhaan /kΛr^han-m^han/, jumhaan /dʒum^han/, karhangcha jumhaan /kΛr^hanʃΛ dʒum^han/, gwaa jumhaan /gwa dʒum^han/, checha mhaan /tʃeʃΛ m^han/, luto /luto/, byangdar /bjaŋdΛr/ ‘measles’, chhiske /tʃ^hiske/ ‘sneezing’, chuheke /tʃuheke/ ‘coughing’, kausul/kΛsul/ or kapsul /kΛpsul/, mingya aanke/minjΛ anke/ or bhiske /b^hiske/, saato aancha /sato anʃΛ/, namsu pahiske /nΛmsu pΛhiske/, haija /hΛjdʒΛ/, maasi /masi/, sul /sul/, tus /tus/ ‘giardiasis’, kuphat /kup^hΛt/, begaar /begaar/, suke begaar /suke begar/, khapate /k^hΛpΛte/, mos /mos/, moch /motʃ/, gaano /gano/, gaanogolaa /ganogola/, sutak baayugolaa /sutΛk bajugola/, chherautyaa /tʃ^heɾΛutja/, raanghaan /raŋ^han/, lakhuwa /lak^huwa/, kharjulo /k^hΛrdʒulo/, somokke /somokke/, thunelo /t^hunelo/, harsaa /hΛrsa/, poksyaa /poksja/ ‘tumor’, naaksyaa /naksja/ ‘small tumor’, gadaame jyaake /gΛdame dʒake/ and so on. Similarly, the public health knowledge in Magars like chhaake /tʃ^hake/, ‘to become ill’, jhercha /dʒ^heɾʃΛ/ ‘healthy’, gepcha /gepʃΛ/ ‘healing’, desaan /desan/ ‘epidemic’, usaahaa /usaha/ ‘medicine, drugs, treatment’, mandaru /mΛndΛru/ ‘patient, ill person’, chhaacha bharmi /tʃ^hatʃΛ b^hΛrmi/ ‘ill person, patient’, laakke /lakke/ ‘to smear’, sittke /sitke/ ‘to broom or to make dry’, di haataakke /di hatakke/ ‘to boil water’ and causative agents, anatomy and physiology, etc. related to nomenclatures in their mother tongues. In contrast, younger Magar peoples are forgetting their indigenous nomenclatures regarding Health, illness and medication (healing) practices of Magars.

Here, the discussed indigenous knowledge in their own language in brief collected in the field through key informant interview, focus group discussion and observation from the field; and detail category-wise is presented in **Annex -IX**:

CHAPTER SEVEN

BELIEFS AND ATTITUDES REGARDING HEALTH, ILLNESS AND HEALING AMONG THE MAGARS

The perception, understanding and beliefs, as well as way of thinking and feelings (attitudes) on health, illness and healing (medication) among the individuals, are constructed from the society, culture and their practices; and started from childhood, retain and gained through all the life period. In general, concepts and perceptions are mental representations, abstract objects or abilities that make up the fundamental building blocks of thoughts and beliefs. The "social factors play in determining or influencing the health of individuals, groups, and the larger society. Social conditions and situations not only promote, in some cases but also cause the possibility of illness and disability" (Cockerham, 2012, p.1). The socio-cultural background factors of the Magars are also playing a role to construct and practice their own perception, understanding, beliefs and attitudes about health, illness and healing or well-being. The socio-cultural background of the Magars is constructed through the long ancestral experiences, adaptation process with the physical and social environment in their ancestral lands.

The "Cultural background has an important influence on many aspects of people's lives including their beliefs, behaviour, rituals, family structure, diet, dress, body image, concepts of space and of time, and attitudes to illness, pain and other forms of misfortune" (Helman, 2007, p.3). Hence, the socio-cultural background of the Magars and their cultural philosophy have influenced to construct perceptions towards ill-health, healing and wellbeing as well as health-seeking behaviours.

In general, accessing the concepts and perceptions of the patients and persons is often difficult but there are substantial issues of epistemology and ethics (Sen, 2004, p. 263) to understanding perceptions of ill-health and medication among the Magars. The Magars of the study area are indigenous peoples. They have constructed their own indigenous epistemology or knowledge, ethics regarding health, illness and healings. However, it is changing due to exposure with other ethnic peoples, modernity, haphazard developments of infrastructures, development of national education system, media and communication system and political development and many more. In this chapter, perceptions, knowledge, beliefs and attitudes of the Magars towards health, illness, healings (medication practices) and well-being are discussed.

7.1 Spiritual Beliefs in Illness and Misfortune

7.1.1 Belief in God-Spiritual

In the research area, the Magars believe in god-spirit (spiritual belief) in the cause of illness and misfortune. The gods of local shrines, *Kulāin* (or *Kuldewatā*), *Bāyu*, ancestral god (*pitri*), *Bhuyānr*, *Sirung*, *Oghyān*, *Ghāntugod* and goddess, god and goddess of Nature (*deurali*, *bhanjyang*, *Chandi*, etc) and several other god and goddess which can cause illness and misfortune. There are also several local gods and goddesses which differ from one village to another and Hitchcock (1966, p. 32) has mentioned godlings for such types of gods. The result obtained from the field survey on the belief in god-spiritual causation for illness and misfortune is discussed here. And, here, continuous rating or graphic rating under non-comparative scaling technique is used in three points to find the answers. It is quite simple and is commonly used in practice (Kothari and Garg, 2015, p.79).

The situation of the belief in god-spirit and association with Age group and sex group-wise is presented in table 7.1:

Table 7.1: Belief in God-spiritual by Age and Sex

Age		Belief in God-spiritual Causation of Illness					Pearson Chi-Square	
		Very much	Somewhat	Unbelief	Don't Know	Total		
Under 25	Count	8	22	9	1	40	Asymp. Sig. (2-sided) .000	
	%	20.0	55.0	22.5	2.5	100		
26 - 35	Count	50	64	11	4	129		
	%	38.8	49.6	8.5	3.1	100		
36 - 45	Count	70	59	11	5	145		
	%	48.3	40.7	7.6	3.4	100		
46 - 55	Count	62	56	11	1	130		
	%	47.7	43.1	8.5	0.8	100		
56 - 65	Count	62	39	5	5	111		
	%	55.9	35.1	4.5	4.5	100		
66 & above	Count	55	24	1	1	81		
	%	67.9	29.6	1.2	1.2	100		
Total	Count	307	264	48	17	636		
	%	48.3	41.5	7.5	2.7	100		
Sex								
Female	Count	169	122	16	11	318		Asymp. Sig. (2-sided) .010
	%	53.1	38.4	5.0	3.5	100		
Male	Count	138	142	32	6	318		
	%	43.4	44.7	10.1	1.9	100		
Total	Count	307	264	48	17	636		
	%	48.3	41.5	7.5	2.7	100		

Source: Filed Survey, 2015.

The table 7.1 shows that the majority of respondents have belief in god-spirit for causing illness and misfortune where 48.3% have strong and 41.5% somewhat beliefs. And only 7.5% of respondents

have a disbelief in god-spiritual causation of illness and misfortune. With the increase of age, the belief also increases. The belief level is slightly higher in females than males in gender-wise.

The Chi-Square (χ^2) test shows, there was a significant association ($\chi^2 = 46.57$, $df = 15$, $p = .000$, it is less than .05) found between the respondents of different *age* wise group in their perception on belief on god-spirit for causation of illness. Similarly, there was a significant association ($\chi^2 = 11.44$, $df = 15$, $p = .010$, it is less than .05) found between the respondent of different *sex*-wise groups in their perception of belief in god-spirit.

The association with education level and religions of the respondent and belief on god-spirit for causation of illness and misfortune is presented in table 7.2:

Table 7.2: Association of Education and Religion with Belief on God-Spirit

Education Level		Belief in God-spiritual Causation of Illness					Pearson Chi-Square	
		Very much	Somewhat	Unbelief	Don't Know	Total		
Illiterate	Count	52	29	6	2	89	Asymp. Sig. (2-sided) .000	
	%	58.4	32.6	6.7	2.2	100		
Literate/ Primary	Count	156	97	14	8	275		
	%	56.7	35.3	5.1	2.9	100		
Lower Secondary	Count	53	39	4	5	101		
	%	52.5	38.6	4.0	5.0	100		
Secondary	Count	34	65	14	2	115		
	%	29.6	56.5	12.2	1.7	100		
Certificate Level/+2	Count	7	24	9	0	40		
	%	17.5	60.0	22.5	0.0	100		
Bachelor & above	Count	5	10	1	0	16		
	%	31.3	62.5	6.3	0.0	100		
Total	Count	307	264	48	17	636		
	%	48.3	41.5	7.5	2.7	100		
Religion								
Traditional or Animist	Count	79	53	9	5	146		Asymp. Sig. (2-sided) .000
	%	54.1	36.3	6.2	3.4	100		
Buddhist	Count	36	40	8	1	85		
	%	42.4	47.1	9.4	1.2	100		
Hindu	Count	167	157	23	9	356		
	%	46.9	44.1	6.5	2.5	100		
Christian	Count	0	1	4	2	7		
	%	0.0	14.3	57.1	28.6	100		
Atheism/ Nastik	Count	1	0	1	0	2		
	%	50.0	0.0	50.0	0.0	100		
Don't Know	Count	24	13	3	0	40		
	%	60.0	32.5	7.5	0.0	100		
Total	Count	307	264	48	17	636		
	%	48.3	41.5	7.5	2.7	100		

Source: Field Survey, 2015.

Table 7.2 shows, lower education levelshad more belief in god-spiritual for causation of illness and misfortune, however, having higher education respondents have partial belief in

god-spiritual. Similarly, religion-wise, those people who were unknown about their religion and animist respondents have more belief in the god-spiritual.

The Chi-Square (χ^2) test shows, there was a significant association ($\chi^2= 62.31$, $df = 15$ and $p = .000$, which is less than .05) found between the respondents of different *education level*-wise group in their perception on belief on god-spirit for causation of illness. Similarly, there was a significant association ($\chi^2= 59.97$, $df = 15$ and $p = .000$, which is less than .05) found between the respondents of different *religion*-wise groups in their perception on belief on god-spirit for causation of illness.

The association with different occupation group and belief on god-spirit in causation of illness and misfortune is presented in table 7.3:

Table 7.3: Association of Occupation with Belief on God-Spirit

Occupation		Belief in God-spiritual Causation of Illness				Total	Pearson Chi-Square
		Very much	Somewhat	Unbelief	Don't Know		
Agriculture	Count	169	140	25	4	338	Asymp. Sig. (2-sided) .001
	%	50.0	41.4	7.4	1.2	100.0	
Job/ service in Nepal	Count	8	17	3	0	28	
	%	28.6	60.7	10.7	0.0	100	
Construction/ Maintenance works	Count	9	9	2	0	20	
	%	45.0	45.0	10.0	0.0	100.0	
Business	Count	9	19	4	1	33	
	%	27.3	57.6	12.1	3.0	100	
Foreign Employment	Count	16	12	4	0	32	
	%	50.0	37.5	12.5	0.0	100	
Job in India	Count	8	10	3	2	23	
	%	34.8	43.5	13.0	8.7	100	
Housewife	Count	20	19	1	5	45	
	%	44.4	42.2	2.2	11.1	100	
Ex-Army/Pensioner/ Army in India or UK	Count	66	32	4	5	107	
	%	61.7	29.9	3.7	4.7	100	
Others	Count	2	6	2	0	10	
	%	20.0	60.0	20.0	0.0	100	
Total	Count	307	264	48	17	636	
	%	48.3	41.5	7.5	2.7	100	

Source: Field survey, 2015.

The table 7.1-3 shows that the respondents having occupation ex-army and pensioners of Indian Gurkha army or the British Gurkha armies (61.7%), foreign employment (50%), Agriculture (50%) had found more belief and respondent who were job-holders in Nepal/teacher (60.7%), other professions (60.0%) found partial beliefs in god-spiritual for causation of illness and misfortune.

The Chi-Square (χ^2) test shows that there was a significant association ($\chi^2= 52.39$, $df = 24$ and $p = .000$, which is less than .05) found between the respondents of different *occupation* wise groups in their perception on belief on god-spirit for causation of illness.

7.1.2 Belief on Causation of Illness in Making God's Thān/shrine Dirty

The traditional culture believes in sanitation of the god than/shrine at the villages. Some shrines are constructed near a water source (*PāniMuhān*) and public places. There were beliefs on illness causation when doing defecation, urination or doing dirty or pollution near shrine due to angry god-spirit of shrine. Here, the result obtained from the survey is presented about beliefs on causation of illness in doing dirty or pollution surrounding *god-thān* or shrine.

The age and sex-wise association with belief on causation of illness in doing dirty or pollution at *god-thān* or shrine are presented in the table 7.4:

Table 7.4: Belief on Causation of Illness in Making Shrine Dirty by Age and Sex

Age		Response				Total	Pearson Chi-Square
		Very much	Somewhat	Unbelief	Don't know		
Under 25	Count	7	19	13	1	40	Asymp. Sig. (2-sided) .000
	%	17.5	47.5	32.5	2.5	100	
26 - 35	Count	52	58	16	3	129	
	%	40.3	45.0	12.4	2.3	100	
36 - 45	Count	73	54	14	4	145	
	%	50.3	37.2	9.7	2.8	100	
46 - 55	Count	64	49	14	3	130	
	%	49.2	37.7	10.8	2.3	100	
56 - 65	Count	56	48	3	4	111	
	%	50.5	43.2	2.7	3.6	100	
66 & above	Count	48	31	2	0	81	
	%	59.3	38.3	2.5	0.0	100	
Total	Count	300	259	62	15	636	
	%	47.2	40.7	9.7	2.4	100	
Sex							
Female	Count	156	131	21	10	318	Asymp. Sig. (2-sided) .035
	%	49.1	41.2	6.6	3.1	100	
Male	Count	144	128	41	5	318	
	%	45.3	40.3	12.9	1.6	100	
Total	Count	300	259	62	15	636	
	%	47.2	40.7	9.7	2.4	100	

Source: Field Survey, 2015.

The Table No 7.4 shows that the respondents of older age group were found to have more beliefs and the younger age groups were partial beliefs in a higher percentage. Female respondents were found with more beliefs than male respondents. In aggregate, majority respondents (more belief 47.2% and partial belief 40.7%) had found belief in the causation illness due to doing dirt or pollution at god-than or shrine.

The Chi-Square (χ^2) test shows that there was a significant association ($\chi^2= 49.09$, $df = 15$ and $p = .000$, which is less than .05) found between the respondents of different *age* wise group in their beliefs on causation of illness doing dirty or pollution on *god-thān* or shrine. Similarly, there was a significant association ($\chi^2= 8.63$, $df = 3$ and $p = .035$, which is less than .05) found between the respondents of different *sex*-wise groups in their beliefs on causation of illness doing dirty or pollution on *god-thān* or shrine.

The education level and religion-wise association with beliefs on causation of illness doing dirty or pollution near the *god-thān* or shrine is presented in table 7.5:

Table 7.5: Belief on Causation of Illness in Making Shrine Polluted or Dirty by Education and Religion

Education Level		Response				Total	Pearson Chi-Square
		Very much	Somewhat	Unbelief	Don't know		
Illiterate	Count	48	37	4	0	89	Asymp. Sig. (2-sided) .000
	%	53.9	41.6	4.5	0.0	100	
Literate/ Primary	Count	149	100	16	10	275	
	%	54.2	36.4	5.8	3.6	100	
Lower Secondary	Count	48	40	9	4	101	
	%	47.5	39.6	8.9	4.0	100	
Secondary	Count	43	53	19	0	115	
	%	37.4	46.1	16.5	0.0	100	
Certificate Level/+2	Count	7	22	10	1	40	
	%	17.5	55.0	25.0	2.5	100	
Bachelor & above	Count	5	7	4	0	16	
	%	31.3	43.8	25.0	0.0	100	
Total	Count	300	259	62	15	636	
	%	47.2	40.7	9.7	2.4	100	
Religion of Respondents							
Traditional or Animist	Count	56	67	19	4	146	Asymp. Sig. (2-sided) .000
	%	38.4	45.9	13.0	2.7	100	
Buddhist	Count	33	41	11	0	85	
	%	38.8	48.2	12.9	0.0	100	
Hindu	Count	187	134	26	9	356	
	%	52.5	37.6	7.3	2.5	100	
Christian	Count	1	2	2	2	7	
	%	14.3	28.6	28.6	28.6	100	
Atheism/ Nastik	Count	1	0	1	0	2	
	%	50.0	0.0	50.0	0.0	100	
Don't Know	Count	22	15	3	0	40	
	%	55.0	37.5	7.5	0.0	100	
Total	Count	300	259	62	15	636	
	%	47.2	40.7	9.7	2.4	100	

Source: Field survey, 2015.

The table 7.5 shows that illiterate and lower education level has more beliefs than higher education level and higher education level respondents have partial belief in the causation of

illness on doing dirty or pollution near shrines. Religion-wise respondents who had no idea about their religion, Hindu were found higher percentage in more belief and animist or Prakitik and Buddhist were found higher percentage in partial belief.

The Chi-Square (χ^2) test shows that there was a significant association ($\chi^2= 52.49$, $df = 15$ and $p = .000$, which is less than .05) found between the respondents of different *education level*-wise groups in their beliefs on causation of illness doing dirty or pollution at *god-thān* or shrine. Similarly, there was a significant association ($\chi^2= 46.36$, $df = 15$ and $p = .000$, which is less than .05) found between the respondents of different *religion*-wise groups in their beliefs on causation of illness doing dirty or pollution at *god-thān* or shrine.

The marital status wise association of beliefs on causation of illness doing dirty or pollution near the *god-thān* or shrine is presented in table 7.6.

Table 7.6: Belief on Causation of Illness in Making Shrine Dirty or Polluted association with Marital Status

Marital Status		Response				Total	Pearson Chi-Square
		Very much	Somewhat	Unbelief	Don't know		
Married	Count	243	212	56	11	522	Asymp. Sig. (2-sided) .005
	%	46.6	40.6	10.7	2.1	100	
Unmarried	Count	3	6	5	1	15	
	%	20.0	40.0	33.3	6.7	100	
Single (Widow/ Widower)	Count	54	40	1	3	98	
	%	55.1	40.8	1.0	3.1	100	
Divorced	Count	0	1	0	0	1	
	%	0.0	100	0.0	0.0	100	
Total	Count	300	259	62	15	636	
	%	47.2	40.7	9.7	2.4	100	

Source: Field Survey, 2015.

The table 7.6 shows, unmarried respondents were found higher percentage in no belief than married, widow/widowers and married, single (widow/widowers), divorced were higher percentage in belief on causation of illness in doing dirty or pollution at the shrine.

The Chi-Square (χ^2) test shows that there was a significant association ($\chi^2= 23.413$, $df = 9$ and $p = .005$, which is less than .05) found between the respondents of different *marital status* wise groups in their beliefs on causation of illness doing dirty or pollution at *god-thān* or shrine.

From the above discussion, the majority of the Magar respondents were found beliefs on causation of illness doing dirty or pollution at *god-thān* or shrine by individual or person. It is helpful to keep better sanitation and prevention of disease. But it is necessary to change their concept from the modern scientific perspective.

7.1.3 Belief in Causation of Illness in Evil-spirits

In Magar villages, *Ghost, Rakchhes, Pichas, Nidani, Kichakani, Nidani*, the soul of immature death person considered as evil-spirits and believed as the causation of illness. The result found from the survey about belief on causation of illness and misfortune of the Magars is discussed below.

The age and sex-wise responses and association about belief on causation of illness and misfortune by the evil-spirit are presented in table 7.7:

Table 7.7: Beliefs on Causation of Illness through Evil-spirit by Age and Sex

Age		Response				Total	Pearson Chi-Square
		Very much	Somewhat	Unbelief	Don't know		
Under 25	Count	3	26	10	1	40	Asymp. Sig. (2-sided) .003
	% within Age	7.5	65.0	25.0	2.5	100	
26 - 35	Count	31	70	25	3	129	
	% within Age	24.0	54.3	19.4	2.3	100	
36 - 45	Count	41	72	26	6	145	
	% within Age	28.3	49.7	17.9	4.1	100	
46 - 55	Count	46	64	18	2	130	
	% within Age	35.4	49.2	13.8	1.5	100	
56 - 65	Count	32	64	13	2	111	
	% within Age	28.8	57.7	11.7	1.8	100	
66 & above	Count	40	29	11	1	81	
	% within Age	49.4	35.8	13.6	1.2	100	
Total	Count	193	325	103	15	636	
	% within Age	30.3	51.1	16.2	2.4	100	
Sex							
Female	Count	113	161	34	10	318	Asymp. Sig. (2-sided) .000
	% within sex	35.5	50.6	10.7	3.1	100	
Male	Count	80	164	69	5	318	
	% within sex	25.2	51.6	21.7	1.6	100	
Total	Count	193	325	103	15	636	
	% within sex	30.3	51.1	16.2	2.4	100	

Source: Field Survey, 2015.

The Table No 7.7 shows, the majority of respondents (more belief 30.3%), partial belief 51.1%) have belief in the causation of illness and misfortune through evil-spirit and only 16.2% respondents did not believe in evil-spiritual.

Respondents of older age group respondents were found in higher percentage in more belief and younger age groups found higher percentage in partial beliefs. Gender-wise, not belief group respondents are more (21.7%) than females (10.7%).

The Chi-Square (χ^2) test shows that there was a significant association ($\chi^2 = 34.238$, $df = 15$ and $p = .003$, which is less than .05) found between the respondents of different age-wise groups in their beliefs on causation of illness and misfortune in evil-spirit. Similarly, there

was a significant association ($\chi^2= 19.230$, $df = 3$ and $p = .000$, which is less than $.05$) found between the respondents of different *sex-wise* groups in their beliefs on causation of illness and misfortune in evil-spirit.

Education and language-wise responses and association with beliefs on causation of illness and misfortune by the evil-spirit are presented in table 7.8:

Table 7.8: Beliefs on Causation of Illness through Evil-spirit by Education and Language

Education		Response				Total	Pearson Chi-Square
		Very much	Somewhat	Unbelief	Don't know		
Illiterate	Count	45	33	10	1	89	Asymp. Sig. (2-sided) .000
	%	50.6	37.1	11.2	1.1	100	
Literate/ Primary	Count	97	135	35	8	275	
	%	35.3	49.1	12.7	2.9	100	
Lower Secondary	Count	29	56	12	4	101	
	%	28.7	55.4	11.9	4.0	100	
Secondary	Count	18	65	30	2	115	
	%	15.7	56.5	26.1	1.7	100	
Certificate Level/+2	Count	3	24	13	0	40	
	%	7.5	60.0	32.5	0.0%	100	
Bachelor & above	Count	1	12	3	0	16	
	%	6.3	75.0	18.8	0.0	100	
Total	Count	193	325	103	15	636	
	%	30.3	51.1	16.2	2.4	100	
Language (Mother Tongue)							
Magar	Count	182	316	94	13	605	Asymp. Sig. (2-sided) .029
	%	30.1	52.2	15.5	2.1	100	
Nepali	Count	11	9	9	2	31	
	%	35.5	29.0	29.0	6.5	100	
Total	Count	193	325	103	15	636	
	%	30.3	51.1	16.2	2.4	100	

Source: Field Survey, 2015.

The table 7.8 shows, respondents having illiterate and lower education level were found higher percentage in more belief and respondents having higher education level were found higher percentage in partial belief. Language-wise, the respondents having Nepali had a slightly higher percentage and having Magar language higher in partial beliefs.

The Chi-Square (χ^2) test shows that there was a significant association ($\chi^2= 61.151$, $df = 15$ and $p = .000$, which is less than $.05$) found between the respondents of different *education level-wise* groups in their beliefs on causation of illness and misfortune in evil-spirit. Similarly, there was a significant association ($\chi^2= 9.020$, $df = 3$ and $p = .000$, which is less than $.05$) found between the respondents of different *language (mother tongue)* wise groups in their beliefs on causation of illness and misfortune in evil-spirit.

The religion and marital status wise responses and association with belief on causation of illness and misfortune by the evil-spirit are presented in table 7.9:

Table 7.9: Beliefs on Causation of Illness through Evil-spirit by Religion and Marital Status

Religion		Response				Total	Pearson Chi-Square
		Very much	Somewhat	Unbelief	Don't know		
Traditional or Animist	Count	36	85	19	6	146	Asymp. Sig. (2-sided) .001
	%	24.7	58.2	13.0	4.1	100	
Buddhist	Count	22	45	17	1	85	
	%	25.9	52.9	20.0	1.2	100	
Hindu	Count	121	172	57	6	356	
	%	34.0	48.3	16.0	1.7	100	
Christian	Count	1	2	2	2	7	
	%	14.3	28.6	28.6	28.6	100	
Atheism/ Nastik	Count	1	0	1	0	2	
	%	50.0	0.0	50.0	0.0	100	
Don't Know	Count	12	21	7	0	40	
	%	30.0	52.5	17.5	0.0	100	
Total	Count	193	325	103	15	636	
	%	30.3	51.1	16.2	2.4	100	
Marital Status							
Married	Count	156	268	86	12	522	Asymp. Sig. (2-sided) .014
	%	29.9	51.3	16.5	2.3	100	
Unmarried	Count	2	5	8	0	15	
	%	13.3	33.3	53.3	0.0	100	
Single (Widow/ Widower)	Count	35	51	9	3	98	
	%	35.7	52.0	9.2	3.1	100	
Divorced	Count	0	1	0	0	1	
	%	0.0	100	0.0	0.0	100	
Total	Count	193	325	103	15	636	
	%	30.3	51.1	16.2	2.4	100	

Source: Field Survey, 2015.

The table 7.9 shows, respondents having traditional or animist religion, Buddhist and respondents who do not know their religion was found higher percentage in partial belief. Marital status-wise unmarried was found majority unmarried (53.3%) did have a belief in evil-spiritual for causation of illness and misfortune.

The Chi-Square (χ^2) test shows that there was a significant association ($\chi^2 = 36.565$, $df = 15$ and $p = .001$, which is less than .05) found between the respondents of different *religion*-wise groups in their beliefs on causation of illness and misfortune in evil-spirit. Similarly, there was a significant association ($\chi^2 = 20.646$, $df = 9$ and $p = .014$, which is less than .05) found between the respondents of different *marital status* wise groups in their beliefs on causation of illness and misfortune in evil-spirit.

7.1.4 Belief in Boksi (Witchcraft and Sorcery)

The belief in witchcraft and sorcery for the causation of illness and misfortune prevails in Nepalese society and culture. The Magars are also a part of Nepalese society and influence witchcraft and sorcery. Here, the results obtained about the perception and belief of Magars towards witchcraft and Sorcery are discussed.

The age and sex-wise response and association with beliefs on witchcraft and sorcery for causation of illness and misfortune are presented in the table 7.10:

Table 7.10: Distribution of Belief in Boksi by Age and Sex

Age		Belief in Witch/Sorcerer (Boksā/Boksi)				Total	Pearson Chi-Square
		Very much	Somewhat	Unbelief	Don't know		
Under 25	Count	2	19	17	2	40	Asymp. Sig. (2-sided) .032
	%	5.0	47.5	42.5	5.0	100	
26 - 35	Count	18	55	52	4	129	
	%	14.0	42.6	40.3	3.1	100	
36 - 45	Count	29	71	40	5	145	
	%	20.0	49.0	27.6	3.4	100	
46 - 55	Count	31	66	31	2	130	
	%	23.8	50.8	23.8	1.5	100	
56 - 65	Count	23	56	25	7	111	
	%	20.7	50.5	22.5	6.3	100	
66 & above	Count	20	35	21	5	81	
	%	24.7	43.2	25.9	6.2	100	
Total	Count	123	302	186	25	636	
	%	19.3	47.5	29.2	3.9	100	
Sex							
Female	Count	64	170	74	10	318	Asymp. Sig. (2-sided) .003
	%	20.1	53.5	23.3	3.1	100	
Male	Count	59	132	112	15	318	
	%	18.6	41.5	35.2	4.7	100	
Total	Count	123	302	186	25	636	
	%	19.3	47.5	29.2	3.9	100	

Source: Field Survey, 2015.

The table 7.10 shows that the majority of Magar respondents (strong 19.3% + somewhat 47.5%) were found to believe in *Boksi/Boksā* to cause illness. In age-wise distribution, the older age groups were found higher percentage in belief in witchcraft than younger age groups and younger groups were found higher percentage in no belief. Gender-wise, females have a higher percentage of believing in witchcraft than males.

The Chi-Square (χ^2) test shows that, there was a significant association ($\chi^2 = 26.620$, $df = 15$ and $p = .032$, which is less than .05) found between the respondents of different age-wise groups in their beliefs in witchcraft and sorcery. Similarly, there was a significant association

($\chi^2 = 13.748$, $df = 3$ and $p = .003$, which is less than .05) found between the respondents of different *sex*-wise groups in their beliefs on witchcraft and sorcery.

The occupation and types of family-wise responses and association of beliefs in witchcraft and sorcery for causation of illness and misfortune are presented in table 7.11:

Table 7.11: Belief in Witchcraft and Sorcery by Occupation and Family Type

Occupation		Belief in Witch/Sorcerer (Boksā/Boksi)				Total	Pearson Chi-Square
		Very much	Somewhat	Unbelief	Don't know		
Agriculture	Count	73	173	79	13	338	Asymp. Sig. (2-sided) .035
	%	21.6	51.2	23.4	3.8	100	
Job/ service in Nepal	Count	2	10	15	1	28	
	%	7.1	35.7	53.6	3.6	100	
Construction/ Maintenance works	Count	3	6	11	0	20	
	%	15.0	30.0	55.0	0.0	100	
Business	Count	3	12	16	2	33	
	%	9.1	36.4	48.5	6.1	100	
Foreign Employment	Count	7	12	13	0	32	
	%	21.9	37.5	40.6	0.0	100	
Job in India	Count	3	12	6	2	23	
	%	13.0	52.2	26.1	8.7	100	
House wife	Count	7	22	14	2	45	
	%	15.6	48.9	31.1	4.4	100	
Ex-Army /Pensioner/ Army in India or UK	Count	23	52	27	5	107	
	%	21.5	48.6	25.2	4.7	100	
Others	Count	2	3	5	0	10	
	%	20.0	30.0	50.0	0.0	100	
Total	Count	123	302	186	25	636	
	%	19.3	47.5	29.2	3.9	100	
Types of Family							
Unitary	Count	65	137	71	5	278	Asymp. Sig. (2-sided) .006
	%	23.4	49.3	25.5	1.8	100	
Joint	Count	58	165	115	20	358	
	%	16.2	46.1	32.1	5.6	100	
Total	Count	123	302	186	25	636	
	%	19.3	47.5	29.2	3.9	100	

Source: Field Survey, 2015.

The table 7.11 shows, respondents having occupation agriculture, job in India, foreign employment, ex-army pensioner of India army or the UK were found higher percentage in believing in *Boksi*. And respondents of the unitary family were found a higher percentage in believing in *Boksi*.

The Chi-Square (χ^2) test shows that there was a significant association ($\chi^2 = 37.926$, $df = 24$ and $p = .035$, which is less than .05) found between the respondents of different *occupation* wise groups in their beliefs in *Boksi*. Similarly, there was a significant association ($\chi^2 =$

12.583, $df = 3$ and $p = .006$, which is less than .05) found between the respondents of different *family type*-wise groups in their beliefs on *Boksi*.

The education and marital status wise responses and association with belief on witchcraft and sorcery for causation of illness and misfortune presented in table 7.12:

Table 7.12: Response in Belief in Boksi by Education and Marital Status

Education		Belief in Witch/Sorcerer (Boksā/Boksi)				Total	Pearson Chi-Square
		Very much	Somewhat	Unbelievable	Don't know		
Illiterate	Count	27	41	19	2	89	Asymp. Sig. (2-sided) .001
	%	30.3	46.1	21.3	2.2	100	
Literate/ Primary	Count	58	136	67	14	275	
	%	21.1	49.5	24.4	5.1	100	
Lower Secondary	Count	22	50	27	2	101	
	%	21.8	49.5	26.7	2.0	100	
Secondary	Count	13	54	44	4	115	
	%	11.3	47.0	38.3	3.5	100	
Certificate Level/+2	Count	2	14	22	2	40	
	%	5.0	35.0	55.0	5.0	100	
Bachelor & above	Count	1	7	7	1	16	
	%	6.3	43.8	43.8	6.3	100	
Total	Count	123	302	186	25	636	
	%	19.3	47.5	29.2	3.9	100	
Marital Status							
Married	Count	98	243	162	19	522	Asymp. Sig. (2-sided) .004
	%	18.8	46.6	31.0	3.6	100	
Unmarried	Count	3	2	10	0	15	
	%	20.0	13.3	66.7	0.0	100	
Single (Widow/ Widower)	Count	22	56	14	6	98	
	%	22.4	57.1	14.3	6.1	100	
Divorced	Count	0	1	0	0	1	
	%	0.0	100	0.0	0.0	100	
Total	Count	123	302	186	25	636	
	%	19.3	47.5	29.2	3.9	100	

Source: Field Survey, 2015.

In table 7.12; the Chi-Square (χ^2) test shows that there was a significant association ($\chi^2 = 38.271$, $df = 15$ and $p = .001$, which is less than .05) found between the respondents of different *education level*-wise groups in their beliefs in *Boksi*. Similarly, there was a significant association ($\chi^2 = 24.543$, $df = 9$ and $p = .004$, which is less than .05) found between the respondents of different *family type*-wise groups in their beliefs in *Boksi*.

7.1.5 Belief on Causation of Illness in Luck/Bad-luck According to Planet Horoscope (Grahadashā)

Belief in luck or bad-luck through *Grahadashā* (planet horoscope) is found in society. According to Hindu mythology, the movement of the planet could affect individuals' luck and

fortune which leads to success in life and well-being. The findings of belief in planet horoscope (*Grahadashā*) are discussed here.

The age and education level-wise opinion and association towards belief on causation of illness and misfortune in luck or bad luck according to the planet horoscope and planet movement (*Grahadashā*) is presented in table 7.13:

Table No 7.13: Belief on Causation of Illness in Luck or Bad-luck according to Planet Horoscope (*Grahadashā*) by Age and Education

Age		Response				Total	Pearson Chi-Square
		Very much	Somewhat	Unbelief	Don't know		
Under 25	Count	3	22	13	2	40	Asymp. Sig. (2-sided) .000
	%	7.5	55.0	32.5	5.0	100	
26 - 35	Count	45	60	19	5	129	
	%	34.9	46.5	14.7	3.9	100	
36 - 45	Count	60	71	12	2	145	
	%	41.4	49.0	8.3	1.4	100	
46 - 55	Count	46	65	16	3	130	
	%	35.4	50.0	12.3	2.3	100	
56 - 65	Count	52	48	7	4	111	
	%	46.8	43.2	6.3	3.6	100	
66 & above	Count	47	27	5	2	81	
	%	58.0	33.3	6.2	2.5	100	
Total	Count	253	293	72	18	636	
	%	39.8	46.1	11.3	2.8	100	
Education							
Illiterate	Count	45	36	6	2	89	Asymp. Sig. (2-sided) .000
	%	50.6	40.4	6.7	2.2	100	
Literate/ Primary	Count	129	113	23	10	275	
	%	46.9	41.1	8.4	3.6	100	
Lower Secondary	Count	46	46	7	2	101	
	%	45.5	45.5	6.9	2.0	100	
Secondary	Count	27	66	21	1	115	
	%	23.5	57.4	18.3	.9	100	
Certificate Level/+2	Count	3	21	14	2	40	
	%	7.5	52.5	35.0	5.0	100	
Bachelor & above	Count	3	11	1	1	16	
	%	18.8	68.8	6.3	6.3	100	
Total	Count	253	293	72	18	636	
	%	39.8	46.1	11.3	2.8	100	

Source: Field survey, 2015.

The table 7.13 shows, majority of respondents (very much 39.8%, somewhat 46.1%) were found having a belief in causation of illness due to planetary movement horoscope (*Grahadashā*). The respondents of the older age were found higher percentage in more belief and younger age groups have higher percentage in partial belief on causation of illness and misfortune in luck or bad-luck according to planet horoscope and planet movement (*Grahadashā*). Similarly, respondents of

illiterate and lower education level groups were found higher percentage in more belief and respondents of higher education level groups were found higher percentage in partial beliefs.

The Chi-Square (χ^2) test shows that there was a significant association ($\chi^2= 50.067$, $df = 15$ and $p = .000$, which is less than .05) found between the respondents of different *age-wise* groups in their beliefs on causation of illness and misfortune in luck or bad-luck according to planet horoscope or planet movement (*Grahadashā*). Similarly, there was a significant association ($\chi^2= 68.783$, $df = 15$ and $p = .000$, which is less than .05) found between the respondents of different *education level-wise* groups in their beliefs on causation of illness and misfortune in luck or bad-luck according to planet horoscope or planet movement (*Grahadashā*).

The occupation and family type-wise response and association of belief on causation of illness in luck or bad-luck according to planet horoscope (*Grahadashā*) are presented in table 7.14:

Table 7.14: Belief on Causation of Illness in Luck or Bad-luck according to Planet Horoscope (*Grahadashā*) by Occupation and Family Type

Occupation		Response				Total	Pearson Chi-Square
		Very much	Somewhat	Unbelief	Don't know		
Agriculture	Count	156	144	33	5	338	Asymp. Sig. (2-sided) .002
	%	46.2	42.6	9.8	1.5	100	
Job/ service in Nepal	Count	5	16	6	1	28	
	%	17.9	57.1	21.4	3.6	100	
Construction/ Maintenance works	Count	7	8	3	2	20	
	%	35.0	40.0	15.0	10.0	100	
Business	Count	7	16	8	2	33	
	%	21.2	48.5	24.2	6.1	100	
Foreign Employment	Count	9	17	5	1	32	
	%	28.1	53.1	15.6	3.1	100	
Job in India	Count	8	10	4	1	23	
	%	34.8	43.5	17.4	4.3	100	
House wife	Count	11	28	3	3	45	
	%	24.4	62.2	6.7	6.7	100	
Ex-Army/Pensioner/ Army in India or UK	Count	50	47	8	2	107	
	%	46.7	43.9	7.5	1.9	100	
Others	Count	0	7	2	1	10	
	%	0.0	70.0	20.0	10.0	100	
Total	Count	253	293	72	18	636	
	%	39.8	46.1	11.3	2.8	100	
Types of family							
Unitary	Count	123	128	22	5	278	Asymp. Sig. (2-sided) .024
	%	44.2	46.0	7.9	1.8	100	
Joint	Count	130	165	50	13	358	
	%	36.3	46.1	14.0	3.6	100	
Total	Count	253	293	72	18	636	
	%	39.8	46.1	11.3	2.8	100	

Source: Field Survey, 2015.

The table 7.14 shows, the respondents from agriculture, ex-army or pensioner of India Gurkha or the British Gurkha army were found higher percentage in more belief and respondents from the housewife, others occupations, foreign employment, jobs in Nepal were found higher percentage in partial belief on causation of illness in luck or bad-luck according to planet horoscope (Grahadashā). Similarly, respondents from unitary family were found higher percentage in more belief.

The Chi-Square (χ^2) test shows that there was a significant association ($\chi^2= 49.429$, $df = 24$ and $p = .002$, which is less than .05) found between the respondents of different *occupation* wise groups in their beliefs on causation of illness and misfortune in luck or bad-luck according to planet horoscope or planet movement (*Grahadshā*). Similarly, there was a significant association ($\chi^2= 9.396$, $df = 3$ and $p = .024$, which is less than .05) found between the respondents of different *family type*-wise groups in their beliefs on causation of illness and misfortune in luck or bad-luck according to planetary movement horoscope (*Grahadshā*).

7.1.6 Likert Scale Distribution of Spiritual Beliefs among the Magars

Likert scale or summated scale analysis is done here to understand the scoring of spiritual belief among the Magar respondent of the survey. The likert statements are given in the table 7.15:

Table 7.15: Likert scale statements about Spiritual beliefs among the Magars

Statements	Agree		Uncertain		Disagree		Total	
	N	%	N	%	N	%	N	%
<i>D 1. Illness is caused by pierce of evil spirits (Ghost, Masan, Pichas, etc.).</i>	315	49.6	259	40.7	62	9.7	636	100
<i>D 2. Illness is caused by when god-spirit get angry with you in not doing worship them properly and timely.</i>	356	56.0	245	38.5	35	5.5	636	100
<i>D 3. Premature dead person's soul could be ghost or pichas and they can cause to illness for humans.</i>	248	39.0	351	50.5	67	10.5	666	100
<i>D 6. When evil eye saw you are eating something and envying can cause to cursed (Begar) then to ill.</i>	235	36.9	295	46.4	106	16.7	636	100
<i>D 14. Worshipping God Goddess or Godlings or ancestor could be prevented from the illness.</i>	267	42.0	319	50.1	50	7.9	636	100
<i>D 16. Offering to worship for God-Goddess or Godling, ancestor god which are worshipping from the traditionally could reduce the illness when suffering from the illness.</i>	304	47.8	300	47.2	32	5.0	636	100

Source: Field Survey, 2015

The above three-degree scale responses likert scale statements about spiritual beliefs among the Magars are analysed and the result is discussed as follows:

Here, according to Kothari and Garg (2015, pp 78-80), if the instruments consists 6 statements (likert scale questions) and three degrees, the following score value would be revealing:

6 x 3 = 18 Most having no belief attitude

6 x 2 = 10 Neural attitude

6 x 1 = 6 Most having belief in spiritual responses.

Hence, here score for any individual would fall between 6 and 18. The score above 12; shows that having no spiritual beliefs and the score below 12 shows that having beliefs on spiritual causation of illness and misfortune and exactly 12 is suggestive of neutral or undecided. The likert scale score distribution of spiritual beliefs for illness and misfortune among the Magars is presented in table 7.16:

Table 7.16: Distribution of Likert Scale Score on Spiritual Believe in Illness and Misfortune

Score	Spiritual Belief			
	Frequency	Percent	Valid Percent	Cumulative Percent
6.00	92	14.5	14.5	14.5
7.00	66	10.4	10.4	24.8
8.00	78	12.3	12.3	37.1
9.00	64	10.1	10.1	47.2
10.00	49	7.7	7.7	54.9
11.00	85	13.4	13.4	68.2
12.00	129	20.3	20.3	88.5
13.00	30	4.7	4.7	93.2
14.00	10	1.6	1.6	94.8
15.00	11	1.7	1.7	96.5
16.00	8	1.3	1.3	97.8
17.00	3	0.5	0.5	98.3
18.00	11	1.7	1.7	100.0
Total	636	100.0	100.0	

Source: Field Survey, 2015

The table 6.16 shows that in likert scale score of the spiritual belief on causation of illness and misfortune, 14.5% of respondents have extreme belief and cumulatively 68.2% respondents believed in spiritual causation of illness and misfortune. Actually, 20.3% of respondents were uncertain about the spiritual belief, only 1.7% respondents have most of no belief in spiritual belief and 11.5% respondents were tended to no belief in causation of illness due to god or evil spirit.

From this discussion, it indicates that spiritual beliefs in the causation of illness and misfortune existed among the Magars.

7.2 Perception about Micro-organism and Non-communicable Diseases

7.2.1 Knowledge towards Micro-organism and Illness

Several illnesses could be caused through the micro-organisms such as bacteria, viruses, fungus, worms, etc, which can be very small and need a microscope to find-out or diagnose causative agents. The knowledge about the micro-organism and causation of illness of Magars result found from field survey is discussed here.

The age and sex-wise distribution of knowledge and association towards micro-organism and causation of illness among the Magars are presented in table 7.17.

Table 7.17: Knowledge Towards Micro-organism for Causation of Illness by Age and Sex

Age		Knowledge about Micro-organism			Total	Pearson Chi-Square
		Known	Heard only	Unknown		
Under 25	Count	28	9	3	40	Asymp. Sig. (2-sided) .000
	% within Age	70.0	22.5	7.5	100	
26 - 35	Count	83	43	3	129	
	% within Age	64.3	33.3	2.3	100	
36 - 45	Count	81	47	17	145	
	% within Age	55.9	32.4	11.7	100	
46 - 55	Count	69	46	15	130	
	% within Age	53.1	35.4	11.5	100	
56 - 65	Count	47	40	24	111	
	% within Age	42.3	36.0	21.6	100	
66 & above	Count	38	25	18	81	
	% within Age	46.9	30.9	22.2	100	
Total	Count	346	210	80	636	
	% within Age	54.4	33.0	12.6	100	
Sex						
Female	Count	150	121	47	318	Asymp. Sig. (2-sided) .001
	% within Sex	47.2	38.1	14.8	100	
Male	Count	196	89	33	318	
	% within Sex	61.6	28.0	10.4	100	
Total	Count	346	210	80	636	
	% within Sex	54.4	33.0	12.6	100	

Source: Field survey, 2015.

The table 7.17 shows majority of respondents (54.4%) claimed having knowledge of micro-organism which can cause illness (germ theory) in Magar society. And there were 33% respondents heard only and 12.6% respondent had no idea about the causation of micro-organism for illness. Younger age groups (age-wise) and male groups (gender-wise) were found higher percentage in a known category.

The Chi-Square (χ^2) test shows, there was a significant association ($\chi^2 = 35.035$, $df = 10$ and $p = .000$, which is less than .05) found between the respondents of different *age* groups in their

knowledge on micro-organism and causation of illness. Similarly, there was a significant association ($\chi^2= 33.442$, $df= 2$ and $p = .001$, which is less than .05) found between the respondents of different sex groups in their knowledge on micro-organism and causation of illness

The education and religion-wise distribution of knowledge and association towards micro-organism and causation of illness among the Magars is presented in table 7.18

Table 7.18: Knowledge towards Micro-organism for Causation of Illness by Education and Religion

Education		Knowledge about Micro-organism			Total	Pearson Chi-Square	
		Known	Heard only	Unknown			
Illiterate	Count	23	32	34	89	Asymp. Sig. (2-sided) .000	
	% within Education	25.8	36.0	38.2	100		
Literate/ Primary	Count	143	101	31	275		
	% within Education	52.0	36.7	11.3	100		
Lower Secondary	Count	58	36	7	101		
	% within Education	57.4	35.6	6.9	100		
Secondary	Count	76	33	6	115		
	% within Education	66.1	28.7	5.2	100		
Certificate Level/+2	Count	33	5	2	40		
	% within Education	82.5	12.5	5.0	100		
Bachelor & above	Count	13	3	0	16		
	% within Education	81.3	18.8	0.0	100		
Total	Count	346	210	80	636		
	% within Education	54.4	33.0	12.6	100		
Religion							
Traditional or Animist	Count	79	58	9	146		Asymp. Sig. (2-sided) .009
	% within Religion	54.1	39.7	6.2	100		
Buddhist	Count	37	31	17	85		
	% within Religion	43.5	36.5	20.0	100		
Hindu	Count	199	107	50	356		
	% within Religion	55.9	30.1	14.0	100		
Christian	Count	4	1	2	7		
	% within Religion	57.1	14.3	28.6	100		
Atheism/ Nastik	Count	1	0	1	2		
	% within Religion	50.0	0.0	50.0	100		
Don't Know	Count	26	13	1	40		
	% within Religion	65.0	32.5	2.5	100		
Total	Count	346	210	80	636		
	% within Religion	54.4	33.0	12.6	100		

Source: Field survey, 2015.

The table 7.18 shows respondents of higher education level were found higher percentage in having knowledge towards micro-organism and causation of illness. Religion-wise respondents do not know their actual religion, Christian and Hindus have a higher percentage in having the knowledge.

The Chi-Square (χ^2) test shows, there was a significant association ($\chi^2= 35.035$, $df = 10$ and $p = .000$, which is less than .05) found between the respondents of different age groups in their

knowledge on micro-organism and causation of illness. Similarly, there was a significant association ($\chi^2= 33.442$, $df= 2$ and $p = .001$, which is less than .05) found between the respondents of different sex groups in their knowledge on micro-organism and causation of illness.

The occupation and marital status wise distribution of knowledge and association towards micro-organism and causation of illness among the Magars is presented in table 7.19

Table 7.19: Knowledge towards Micro-organism for Causation of Illness by Occupation and Marital Status

Occupation		Knowledge about Micro-organism			Total	Pearson Chi-Square
		Known	Heard only	Un-Known		
Agriculture	Count	159	127	52	338	Asymp. Sig. (2-sided) .049
	% within Occupation	47.0	37.6	15.4	100	
Job/ service in Nepal	Count	19	7	2	28	
	% within Occupation	67.9	25.0	7.1	100	
Construction/ Maintenance works	Count	13	5	2	20	
	% within Occupation	65.0	25.0	10.0	100	
Business	Count	24	8	1	33	
	% within Occupation	72.7	24.2	3.0	100	
Foreign Employment	Count	21	10	1	32	
	% within Occupation	65.6	31.3	3.1	100	
Job in India	Count	13	8	2	23	
	% within Occupation	56.5	34.8	8.7	100	
House wife	Count	26	16	3	45	
	% within Occupation	57.8	35.6	6.7	100	
Ex-Army/ Pensioner/ Army in India or UK	Count	64	26	17	107	
	% within Occupation	59.8	24.3	15.9	100	
Others	Count	7	3	0	10	
	% within Occupation	70.0	30.0	0.0	100	
Total	Count	346	210	80	636	
	% within Occupation	54.4	33.0	12.6	100	
Marital Status						
Married	Count	296	171	55	522	Asymp. Sig. (2-sided) .000
	% within Marital Status	56.7	32.8	10.5	100	
Unmarried	Count	13	2	0	15	
	% within Marital Status	86.7	13.3	0.0	100	
Single (Widow/ Widower)	Count	37	36	25	98	
	% within Marital Status	37.8	36.7	25.5	100	
Divorced	Count	0	1	0	1	
	% within Marital Status	0.0	100	0.0	100	
Total	Count	346	210	80	636	
	% within Marital Status	54.4	33.0	12.6	100	

Source: Field Survey, 2015.

The table 7.19 shows, respondents of having an occupation such as a business, jobs/service in Nepal, foreign employment were found a higher percentage in having knowledge about micro-organism and illness. Marital status-wise unmarried groups were found higher percentage in having the knowledge.

The Chi-Square (χ^2) test shows, there was a significant association ($\chi^2= 26.345$, $df = 16$ and $p = .049$, which is less than .05) found between the respondents of different *occupation* groups in their knowledge on micro-organism and causation of illness. Similarly, there was a significant association ($\chi^2= 29.227$, $df = 6$ and $p = .000$, which is less than .05) found between the respondents of different *marital status* wise groups in their knowledge on micro-organism and causation of illness.

7.2.2 Likert Scale Distribution on Causation of Illness from Micro-organism

Micro-organisms are causes of various illnesses and they have different transmission routes from one to another. And the habit of taking boiled water for drinking and sanitation could prevent many more illnesses. The table 7.20 presents likert scale statement about micro-organism:

Table 7.20: Likert Scale Statements on Causation of Illness from Micro-organism

Statements	Agree		Uncertain		Disagree		Total	
	N	%	N	%	N	%	N	%
<i>D 5. Microscopic bacteria, viruses, protozoa and worms, etc are causative organisms of illness.</i>	520	81.8	112	17.6	4	0.6	636	100
<i>D 11. Gastrointestinal infections and diseases are reduced when taking boiling water for drinking.</i>	565	88.8	64	10.1	7	1.1	636	100

Source: Field Survey 2015

Here, the findings of the above two likert scale statements about causation of illness from Micro-organism are discussed gathered from the field.

According to Kothari and Garg (2015, pp 78-80), if the instruments consists 2 statements (likert scale questions) and three degrees, the following score value would be revealing:

$2 \times 3 = 6$ Most of unfavourable attitudes;

$2 \times 2 = 4$ neural attitude;

$2 \times 1 = 2$ Most of favourable responses,

Hence, here score for any individual would fall between 2 and 6. The score above 4; it shows that having negative perception and the score below 4 shows that having positive perception towards micro-organism for causation of illness and benefit of drinking boiled water, and exactly 4 is suggestive of neutral or undecided. The likert scale score distribution of knowledge towards micro-organism for causation of illness and benefit of drinking boiled water among the Magars is presented in table 7.21:

Table 7.21: Distribution of Likert Scale Score on knowledge towards micro-organism for causation of illness and benefit of drinking boiled water

Score	Knowledge on Micro-organism for Causation of Illness			
	Frequency	Percent	Valid Percent	Cumulative Percent
2.00	481	75.6	75.6	75.6
3.00	116	18.2	18.2	93.9
4.00	36	5.7	5.7	99.5
5.00	2	0.3	0.3	99.8
6.00	1	0.2	0.2	100.0
Total	636	100.0	100.0	

Source: Field Survey, 2015.

The table 7.21 shows that respondents of 75.6% were found to have more positive responses about the micro-organism for causation of illness and benefit of drinking boiled water and cumulatively 93.9% respondents found positive knowledge towards micro-organism for causation of illness and benefit of drinking boiled water. However, 5.7% of respondents were found uncertain or undecided about the subjects. Only 0.5% of respondents disagreed with the Likert scale statements regarding micro-organism for causation of illness and benefit of drinking boiled water.

7.2.3 Likert Scale Distribution on Importing Communicable Illness

Nepal's economy is sustained on remittance and many youths have migrated to foreign countries including India. The mobility of the persons or migrated persons could import illness into villages and transmit to others; such as HIV/AIDS, Hepatitis B & C, Venereal diseases, Corona Virus and other communicable in the villages. The likert scale statements about understanding importing communicable illness from those migrant persons who go for searching jobs or better economic condition in returning the villages are:

Table 7. 22: Likert Scale Statements on Importing Communicable Illness from those Migrants

Statements	Agree		Uncertain		Disagree		Total	
	N	%	N	%	N	%	N	%
<i>D 19. Peoples who have gone to India or a foreign country can be returned by bringing communicable diseases.</i>	337	53	268	42.1	31	4.9	636	100
<i>D 20. Communicable disease can be transmitted one to another people which are fetched by who were returned from India or foreign country.</i>	324	50.9	296	46.6	16	2.5	636	100

Source: Field Survey, 2015

The above three-degree scales responses Likert Scale statements about knowledge of importing communicable are analysed and the result is discussed as follows:

According to Kothari and Garg (2015, pp 78-80), if the instruments consists 2 statements (Likert scale questions) and three degrees, the following score value would be revealing:

2 x 3 = 6 Most of unfavourable attitudes

2 x 2 = 4 neutral attitude

2 x 1 = 2 Most of favourable responses

Hence, here score for any individual would fall between 2 and 6. The score above 4 shows that having negative perception and the score below 4 shows having positive perception towards communicable illness could be imported by persons who migrated to foreign country or India or far away from home for seeking jobs or better opportunity and transmit others, and exactly 4 is suggestive of neutral or undecided. The Likert scale score distribution of knowledge towards those people who could import communicable disease and transmit others among the Magars is presented in table 7.23

Table 7.23: Distribution of Likert Scale score on Knowledge towards People who could Import Communicable Illness and Transmit others

Score	Knowledge about Importing Communicable Illness			
	Frequency	Percent	Valid Percent	Cumulative Percent
2.00	286	45.0	45.0	45.0
3.00	74	11.6	11.6	56.6
4.00	253	39.8	39.8	96.4
5.00	14	2.2	2.2	98.6
6.00	9	1.4	1.4	100.0
Total	636	100.0	100.0	

Source: Field Survey, 2015.

The table 7.23 shows that, respondents of 45% were found more aware and cumulatively 56% of respondents had the knowledge about the possibility of import communicable illness due to migrant person for employment or better economic condition in the villages. Further, 39.8% of respondents were uncertain about the statement and 3.6% of respondents disagreed with the statements.

7.2.4 Perception towards Cause of Increasing Non-communicable Disease

In recent years; non-communicable illnesses such as hypertension, diabetes mellitus, chronic Kidney failure (CKD), Cancer, etc. are increasing in society. The perception towards the cause of increasing non-communicable illness in the community is discussed here.

The education level-wise distribution of perception and association towards the cause of increasing non-communicable disease among the Magars is presented in table 7.24:

Table 7.24: Perception in Cause of Increasing Non-communicable Disease by Education

Education Level		Cause of Increasing Non-communicable Disease						Total	Pearson Chi-Square
		Modern food habit	Sedentary lifestyle	Careless in food taking habit	Misuse of modern medicines	Taking lots of tension/ thinking	Don't know		
Illiterate	Count	18	15	20	11	3	22	89	Asymp. Sig. (2-sided) .000
	%	20.2%	16.9	22.5	12.4	3.4	24.7	100	
Literate/ Primary	Count	89	52	75	25	9	25	275	
	%	32.4%	18.9	27.3	9.1	3.3	9.1	100	
Lower Secondary	Count	36	16	32	7	3	7	101	
	%	35.6	15.8	31.7	6.9	3.0	6.9	100	
Secondary	Count	41	18	41	10	5	0	115	
	%	35.7	15.7	35.7	8.7	4.3	0.0	100	
Certificate Level/+2	Count	17	4	15	1	1	2	40	
	%	42.5	10.0	37.5	2.5	2.5	5.0	100	
Bachelor & above	Count	8	0	5	1	1	1	16	
	%	50.0	0.0	31.3	6.3	6.3	6.3	100	
Total	Count	209	105	188	55	22	57	636	
	%	32.9	16.5	29.6	8.6	3.5	9.0	100	

Source: Field Survey, 2015.

The table 7.24 shows, respondents of 32.9% told modern food, 16.5% opined sedentary lifestyle, 29.6% said careless in food taking habit, 8.6% told misuse of modern medicines, 3.5% of respondents agreed about mental tension and 9% respondents had no idea about the cause of increasing non-communicable diseases. Overall, the majority of respondents had taken food habits (32.9%+29.6%) about the reason of increasing of non-communicable diseases. Education-wise respondents of higher education levels were found perception of modern food habits and careless in taking food in cause of increasing non-communicable diseases.

The Chi-Square (χ^2) test shows, there was a significant association ($\chi^2 = 57.367$, $df = 25$ and $p = .000$, which is less than .05) found between the respondents of different education level groups in their perception on increasing non-communicable illness.

The age and marital status wise distribution of perception and association towards the cause of increasing non-communicable disease among the Magars is presented in table 7.25:

Table 7.25: Perception in Cause of Increasing Non-communicable Diseases by Age and Marital Status

Age		Cause of Increasing Non-communicable Disease						Total	Pearson Chi-Square	
		Modern food habit	Sedentary lifestyle	Careless in food taking habit	Misuse of modern medicines	Taking lots of tension/thinking	Don't know			
Under 25	Count	16	5	15	2	1	1	40	Asymp. Sig. (2-sided) .002	
	%	40.0	12.5	37.5	5.0	2.5	2.5	100		
26 - 35	Count	44	13	50	13	4	5	129		
	%	34.1	10.1	38.8	10.1	3.1	3.9	100		
36 - 45	Count	59	25	37	10	5	9	145		
	%	40.7	17.2	25.5	6.9	3.4	6.2	100		
46 - 55	Count	45	20	33	15	6	11	130		
	%	34.6	15.4	25.4	11.5	4.6	8.5	100		
56 - 65	Count	32	20	32	9	2	16	111		
	%	28.8	18.0	28.8	8.1	1.8	14.4	100		
66 & above	Count	13	22	21	6	4	15	81		
	%	16.0	27.2	25.9	7.4	4.9	18.5	100		
Total	Count	209	105	188	55	22	57	636		
	%	32.9	16.5	29.6	8.6	3.5	9.0	100		
Marital Status										
Married	Count	173	93	158	41	19	38	522		Asymp. Sig. (2-sided) .023
	%	33.1	17.8	30.3	7.9	3.6	7.3	100		
Unmarried	Count	8	0	5	1	0	1	15		
	%	53.3	0.0	33.3	6.7	0.0	6.7	100		
Single (Widow/Widower)	Count	28	11	25	13	3	18	98		
	%	28.6	11.2	25.5	13.3	3.1	18.4	100		
Divorced	Count	0	1	0	0	0	0	1		
	%	0.0	100.0	0.0	0.0	0.0	0.0	100		
Total	Count	209	105	188	55	22	57	636		
	%	32.9	16.5	29.6	8.6	3.5	9.0	100		

Source: Field Survey, 2015.

The table 7.25 shows that respondents of younger age groups were found a higher percentage in telling food habits for increasing the non-communicable diseases in the society. And marital status-wise, unmarried groups were found higher percentage in telling food habit for increasing the non-communicable diseases in the society.

The Chi-Square (χ^2) test shows, there was a significant association ($\chi^2= 50.718$, $df = 25$ and $p = .002$, which is less than .05) found between the respondents of different *age* groups in their perception on increasing non-communicable illness. Similarly, there was a significant association ($\chi^2= 27.797$, $df = 15$ and $p = .023$, which is less than .05) found between the respondents of different *marital status* groups in their perception on increasing non-communicable illness.

7.3 Perception towards Reproductive Health and HIV/AIDS

7.3.1 Perception in Pregnancy and Drugs

In pregnancy, some modern drugs might be harmful to the foetus taken by the mother through self medication practice. In Nepalese society self medication and misuse of medicine is also in practice. The knowledge towards side effects of medicine in pregnancy is discussed here in the basis of field survey.

The age and marital status wise responses and association towards knowledge about drug's side effect for foetus in pregnancy is presented in table 7.26:

Table 7.26: Knowledge on Drugs in Pregnancy and Foetus Health by Age and Marital Status

Age of respondents		Response			Total	Pearson Chi-Square
		Known	Heard only	Unknown		
Under 25	Count	31	8	1	40	Asymp. Sig. (2-sided) .000
	% within Age	77.5	20.0	2.5	100	
26 - 35	Count	83	40	6	129	
	% within Age	64.3	31.0	4.7	100	
36 - 45	Count	73	61	11	145	
	% within Age	50.3	42.1	7.6	100	
46 - 55	Count	55	58	17	130	
	% within Age	42.3%	44.6	13.1	100	
56 - 65	Count	42	56	13	111	
	% within Age	37.8	50.5	11.7	100	
66 & above	Count	26	39	16	81	
	% within Age	32.1	48.1	19.8	100	
Total	Count	310	262	64	636	
	% within Age	48.7	41.2	10.1	100	
Marital Status						
Married	Count	269	209	44	522	Asymp. Sig. (2-sided) .001
	% within Marital Status	51.5	40.0	8.4	100	
Unmarried	Count	10	4	1	15	
	% within Marital Status	66.7	26.7	6.7	100	
Single (Widow/Widower)	Count	31	48	19	98	
	% within Marital Status	31.6	49.0	19.4	100	
Divorced	Count	0	1	0	1	
	% within Marital Status	0.0	100.0	0.0	100	
Total	Count	310	262	64	636	
	% within Marital Status	48.7	41.2	10.1	100	

Source: Field survey, 2015.

The table 7.26 shows the Magar respondents of 48.7% were found having knowledge and awareness towards the modern drugs could be harmful or create side effects for foetus in pregnancy in doing misuse or taking without doctor's recommendation. And 41.2% respondents had only heard and 10.1% respondents were unknown about the problem. Age

wise, younger age groups were found higher percentage in known and middle age adult groups respondent were found higher percentage in heard only. Marital status wise unmarried status respondents were found higher percentage in known about the subject.

The Chi-Square (χ^2) test shows that, there was significant association ($\chi^2= 48.929$, $df = 10$ and $p = .000$, which is less than .05) found between the respondents of different *age* wise groups in their knowledge on drugs in pregnancy and foetus health. Similarly, there was significant association ($\chi^2= 21.540$, $df = 6$ and $p = .001$, which is less than .05) found between the respondents of different *marital status* wise groups in their knowledge on drugs in pregnancy and foetus health.

The education and language wise responses and association with knowledge about misuse of drugs and harmful to foetus in pregnancy is presented in table 7.27.

Table 7.27: Knowledge on Drugs in Pregnancy and Foetus Health by Education and Language

Education of respondents		Response			Total	Pearson Chi-Square
		Known	Heard only	Unknown		
Illiterate	Count	25	44	20	89	Asymp. Sig. (2-sided) .000
	% within Education	28.1	49.4	22.5	100	
Literate/ Primary	Count	113	132	30	275	
	% within Education	41.1	48.0	10.9	100	
Lower Secondary	Count	53	42	6	101	
	% within Education	52.5	41.6	5.9	100	
Secondary	Count	72	36	7	115	
	% within Education	62.6	31.3	6.1	100	
Certificate Level/+2	Count	35	5	0	40	
	% within Education	87.5	12.5	0.0	100	
Bachelor & above	Count	12	3	1	16	
	% within Education	75.0	18.8	6.3	100	
Total	Count	310	262	64	636	
	% within Education	48.7	41.2	10.1	100	
Language of respondents						
Magar	Count	289	256	60	605	Asymp. Sig. (2-sided) .040
	% within language	47.8	42.3	9.9	100	
Nepali	Count	21	6	4	31	
	% within language	67.7	19.4	12.9	100	
Total	Count	310	262	64	636	
	% within language	48.7	41.2	10.1	100	

Source: Field survey, 2015.

The table 7.27 shows, respondents of having higher education level were found higher percentage in having knowledge about the misuse of drugs and which could harm to foetus in pregnancy. Language-wise respondents having Nepali language as mother tongues were found higher percentage in known.

The Chi-Square (χ^2) test shows, there was significant association ($\chi^2= 69.336$, $df = 10$ and $p = .000$, which is less than $.05$) found between the respondents of different *education level* wise groups in their knowledge on drugs in pregnancy and foetus health. Similarly, there was significant association ($\chi^2= 6.448$, $df = 2$ and $p = .040$, which is less than $.05$) found between the respondents of different *language* wise groups in their knowledge on drugs in pregnancy and foetus health.

The education and language wise responses and association with knowledge about misuse of drugs and harmful to foetus in pregnancy is presented in table 7.28:

Table 7.28: Knowledge on Drugs in Pregnancy and Foetus Health by Occupation

Occupation		Responses			Total	Pearson Chi-Square
		Known	Heard only	Unknown		
Agriculture	Count	150	152	36	338	Asymp. Sig. (2-sided) .001
	% within Occupation	44.4	45.0	10.7	100	
Job/ service in Nepal	Count	24	3	1	28	
	% within Occupation	85.7	10.7	3.6	100	
Construction/ Maintenance works	Count	7	11	2	20	
	% within Occupation	35.0	55.0	10.0	100	
Business	Count	25	7	1	33	
	% within Occupation	75.8	21.2	3.0	100	
Foreign Employment	Count	13	17	2	32	
	% within Occupation	40.6	53.1	6.3	100	
Job in India	Count	11	8	4	23	
	% within Occupation	47.8	34.8	17.4	100	
House wife	Count	26	16	3	45	
	% within Occupation	57.8	35.6	6.7	100	
Ex-Army/Pensioner/ Army in India or UK	Count	46	46	15	107	
	% within Occupation	43.0	43.0	14.0	100	
Others	Count	8	2	0	10	
	% within Occupation	80.0	20.0	0.0	100	
Total	Count	310	262	64	636	
	% within Occupation	48.7	41.2	10.1	100	

Source: Field survey, 2015.

The table 7.28 shows respondents having occupation job/service in Nepal and business were higher percentage in known about the harmful effect from the self-medication or misuse of medicine without doctor's prescription in pregnancy. However, majority population was found not knowing the subject of drugs and side effects on foetus in pregnancy because heard only group have not found scientific knowledge about the drugs and pregnancy.

The Chi-Square (χ^2) test shows, there was significant association ($\chi^2= 41.061$, $df = 16$ and $p = .001$, which is less than $.05$) found between the respondents of different *occupation* wise groups in their knowledge on drugs in pregnancy and foetus health.

The income source of household wise responses and association knowledge about misuse of drugs and harmful to foetus in pregnancy is presented in table 7.29

Table 7.29: Knowledge on Drugs in Pregnancy and Foetus Health by Income Source of Household

Income Source of Household		Response			Total	Pearson Chi-Square
		Known	Heard only	Unknown		
Agriculture	Count	34	33	8	75	Asymp. Sig. (2-sided) .005
	% within Income Source	45.3	44.0	10.7	100	
Agriculture, labour or wage's works, Skill works	Count	10	22	3	35	
	% within Income Source	28.6	62.9	8.6	100	
Agriculture, Private Job in India or equivalence	Count	25	30	13	68	
	% within Income Source	36.8	44.1	19.1	100	
Agriculture, Business/ small Entrepreneurships	Count	22	6	0	28	
	% within Income Source	78.6	21.4	0.0	100	
Agriculture, Service/ Jobs in other sector	Count	10	7	3	20	
	% within Income Source	50.0	35.0	15.0	100	
Agriculture, teacher/Nepal Army/Police/Govt. Job/Pension	Count	30	23	2	55	
	% within Income Source	54.5	41.8	3.6	100	
Other sources not including Agriculture (e.g. Job, foreign employment, Business etc)	Count	30	11	1	42	
	% within Income Source	71.4	26.2	2.4	100	
Agriculture, Foreign employment (Gulf, Malaysia or equivalent)	Count	58	52	15	125	
	% within Income Source	46.4	41.6	12.0	100	
Agriculture, Indian Army/police or Pension	Count	79	65	17	161	
	% within Income Source	49.1	40.4	10.6	100	
Agriculture, Foreign Employment (Korea, Afghanistan, Iraq, Europe, America or equivalent)	Count	8	10	2	20	
	% within Income Source	40.0	50.0	10.0	100	
Agriculture, British Army/Singapore Police or Pensioner	Count	4	3	0	7	
	% within Income Source	57.1	42.9	0.0	100	
Total	Count	310	262	64	636	
	% within Income Source	48.7	41.2	10.1	100	

Source: Field survey, 2015.

The table 7.29 shows, respondents who have income source form business, small enterprises including agriculture groups, other sources excluding agriculture groups were found higher percentage in known about the effects of drugs in pregnancy. The Chi-Square (χ^2) test shows, there was significant association ($\chi^2 = 40.279$, $df = 20$ and $p = .005$, which is less than .05) found between the respondents of different *income source of household* wise groups in their knowledge on drugs in pregnancy and foetus health.

7.3.2 Knowledge about Eclampsia and Pre-eclampsia in Pregnancy

In the last three months of pregnancy in gestation period, if two of among the given three signs: (1) Increasing blood pressure (specially diastolic higher than 90 mmhg or higher with 20 MmHg in normal BP) (2) oedema of ankles, fingers or faces (3) albumin (protein) in urine, has been seen in the pregnant women could be condition *eclampsia* and *pre-eclampsia* which could be lead to complication of fits, stroke, APH (anti partum haemorrhage), premature labour, death of baby, death of mother (Kafle & Pinniger, 1999, pp.324-325). This condition is dangerous to the mother and foetus; therefore, immediately hospitalization is needed. The perception and awareness towards dangerous and risk conditions in pregnancy is discussed here on the basis of field survey.

The sex and age wise perception and association of *eclampsia* and *pre-eclampsia* condition in pregnancy among the respondents is presented in table 7.30:

Table 7.30: Perception about the Eclampsia and Pre-eclampsia Condition in Pregnancy by Age and Sex

Sex		Response				Total	Pearson Chi-Square	
		General condition	Condition of Illness	Danger sign of pregnancy	Don't Know			
Female	Count	11	49	197	61	318	Asymp. Sig. (2-sided) .030	
	%	3.5	15.4	61.9	19.2	100		
Male	Count	14	75	164	65	318		
	%	4.4	23.6	51.6	20.4	100		
Total	Count	25	124	361	126	636		
	%	3.9	19.5	56.8	19.8	100		
Age								
Under 25	Count	1	4	31	4	40		Asymp. Sig. (2-sided) .000
	%	2.5	10.0	77.5	10.0	100		
26 - 35	Count	6	24	91	8	129		
	%	4.7	18.6	70.5	6.2	100		
36 - 45	Count	9	23	89	24	145		
	%	6.2	15.9	61.4	16.6	100		
46 - 55	Count	3	28	73	26	130		
	%	2.3	21.5	56.2	20.0	100		
56 - 65	Count	4	29	47	31	111		
	%	3.6	26.1	42.3	27.9	100		
66 & above	Count	2	16	30	33	81		
	%	2.5	19.8	37.0	40.7	100		
Total	Count	25	124	361	126	636		
	%	3.9	19.5	56.8	19.8	100		

Source: Field Survey, 2015.

The table 7.30 shows that, the respondents of 56.8% were found aware about the illness of eclampsia and pre-eclampsia and however, unknown respondents (19.8%) and taking minor illness respondents (19.5%) also high number in percentage which indicates proper awareness toward maternal and child health could be low condition in Magar villages. Gender wise

female were higher percentage in awareness than males and age-wise younger age groups were higher percentage than older age groups.

The Chi-Square (χ^2) test shows, there was significant association ($\chi^2= 8.955$, $df = 3$ and $p = .030$, which is less than .05) found between the respondents of different *sex* wise groups in their perception on condition of eclampsia and pre-eclampsia in pregnancy. Similarly, there was significant association ($\chi^2= 63.203$, $df = 15$ and $p = .000$, which is less than .05) found between the respondents of different *age* wise groups in their perception on condition of eclampsia and pre-eclampsia in pregnancy.

The education level and religion wise perception and association of eclampsia and pre-eclampsia condition in pregnancy among the respondents is presented in table 7.31:

Table 7.31: Perception about the Eclampsia and Pre-eclampsia Condition in Pregnancy by Education and Religion

Education level		Responses				Total	Pearson Chi-Square
		General condition	Condition of Illness	Danger sign of pregnancy	Don't Know		
Illiterate	Count	4	18	33	34	89	Asymp. Sig. (2-sided) .000
	%	4.5	20.2	37.1	38.2	100	
Literate/ Primary	Count	10	55	149	61	275	
	%	3.6	20.0	54.2	22.2	100	
Lower Secondary	Count	5	21	61	14	101	
	%	5.0	20.8	60.4	13.9	100	
Secondary	Count	5	23	75	12	115	
	%	4.3	20.0	65.2	10.4	100	
Certificate Level/+2	Count	1	5	31	3	40	
	%	2.5	12.5	77.5	7.5	100	
Bachelor & above	Count	0	2	12	2	16	
	%	0.0	12.5	75.0	12.5	100	
Total	Count	25	124	361	126	636	
	%	3.9	19.5	56.8	19.8	100	
Religion							
Traditional or Animist	Count	7	29	89	21	146	Asymp. Sig. (2-sided) .031
	%	4.8	19.9	61.0	14.4	100	
Buddhist	Count	1	14	62	8	85	
	%	1.2	16.5	72.9	9.4	100	
Hindu	Count	16	76	177	87	356	
	%	4.5	21.3	49.7	24.4	100	
Christian	Count	0	0	5	2	7	
	%	0.0	0.0	71.4	28.6	100	
Atheism/ Nastik	Count	0	0	2	0	2	
	%	0.0	0.0	100	0.0	100	
Don't Know	Count	1	5	26	8	40	
	%	2.5	12.5	65.0	20.0	100	
Total	Count	25	124	361	126	636	
	%	3.9	19.5	56.8	19.8	100	

Source: Field Survey, 2015.

The table 7.31 shows respondents of higher education level were higher percentage in having awareness to the condition of eclampsia and pre-eclampsia in pregnancy. Religion wise Christian, Buddhist, Atheism/ Nastik had higher percentage than other religions.

The Chi-Square (χ^2) test shows, there was significant association ($\chi^2 = 41.280$, $df = 15$ and $p = .000$, which is less than .05) found between the respondents of different *education level* wise groups in their perception on condition of eclampsia and pre-eclampsia in pregnancy. Similarly, there was significant association ($\chi^2 = 26.774$, $df = 15$ and $p = .031$, which is less than .05) found between the respondents of different *religion* wise groups in their perception on condition of eclampsia and pre-eclampsia in pregnancy.

The education level and religion wise perception and association of eclampsia and pre-eclampsia condition in pregnancy among the respondents is presented in table 7.32:

Table 7.32: Perception about the Eclampsia and Pre-eclampsia Condition in Pregnancy by Occupation

Occupation		Responses				Total	Pearson Chi-Square
		General condition	Condition of Illness	Danger sign of pregnancy	Don't Know		
Agriculture	Count	20	63	178	77	338	Asymp. Sig. (2-sided) .003
	%	5.9	18.6	52.7	22.8	100	
Job/ service in Nepal	Count	0	5	20	3	28	
	%	0.0	17.9	71.4	10.7	100	
Construction/ Maintenance works	Count	2	6	12	0	20	
	%	10.0	30.0	60.0	0.0	100.	
Business	Count	0	5	24	4	33	
	%	0.0	15.2	72.7	12.1	100	
Foreign Employment	Count	2	8	18	4	32	
	%	6.3	25.0	56.3	12.5	100	
Job in India	Count	0	7	13	3	23	
	%	0.0	30.4	56.5	13.0	100	
House wife	Count	0	5	37	3	45	
	%	0.0	11.1	82.2	6.7	100	
Ex-Army/Pensioner/ Army in India or UK	Count	1	23	52	31	107	
	%	0.9	21.5	48.6	29.0	100	
Others	Count	0	2	7	1	10	
	%	0.0	20.0	70.0	10.0	100	
Total	Count	25	124	361	126	636	
	%	3.9	19.5	56.8	19.8	100.0	

Source: Field Survey, 2015.

The table 7.32 shows respondents having occupation as like Housewife, business and job/service in Nepal were higher percentage in aware knowledge in condition of eclampsia and pre-eclampsia in pregnancy than other occupation groups.

The Chi-Square (χ^2) test shows that, there was significant association ($\chi^2 = 47.228$, $df = 24$ and $p = .003$, which is less than .05) found between the respondents of different *occupation* wise groups in their perception on condition of eclampsia and pre-eclampsia in pregnancy.

7.3.3 Knowledge about Cutting Umbilical Cord in Home Delivery

In villages, there is difficult to the health facilities, most of the pregnant women give birth to babies at home. During home delivery, some traditional practices such as giving birth in cowshed, cutting umbilical by unsterilized sickle/knife or using cow-dung and unhygienic conditions which could cause to Tetanus and other infectious diseases for a new born baby and mother, and risky for maternal child health. The results of perception of Magars about cutting umbilical cord in giving birth at home (delivery at home) are discussed here based on a field survey.

The age and education-wise perception and association about the cutting umbilical cord in giving childbirth at home for maternal child health are presented in table 7.33:

Table 7.33: Perception on Cutting Umbilical Cord in Home-Delivery by Age and Education

Age		Cutting the Umbilical Cord after the Childbirth at Home					Total	Pearson Chi-Square
		Whatever Available	Clean Sickle/Small Sickle Knife	Clean Blade, Scissors	Sterilized Blade, Scissors	Fresh Split Cane (Choyān)		
Under 25	Count	0	0	14	26	0	40	Asymp. Sig. (2-sided) .000
	%	0.0	0.0	35.0	65.0	0.0	100	
26 - 35	Count	4	6	68	50	1	129	
	%	3.1	4.7	52.7	38.8	0.8	100	
36 - 45	Count	0	14	82	49	0	145	
	%	0.0	9.7	56.6	33.8	0.0	100	
46 - 55	Count	1	14	76	38	1	130	
	%	0.8	10.8	58.5	29.2	0.8	100	
56 - 65	Count	2	14	63	32	0	111	
	%	1.8	12.6	56.8	28.8	0.0	100	
66 & above	Count	1	24	39	17	0	81	
	%	1.2	29.6	48.1	21.0	0.0	100	
Total	Count	8	72	342	212	2	636	
	%	1.3	11.3	53.8	33.3	0.3	100	
Education Level								
Illiterate	Count	3	23	51	11	1	89	
	%	3.4	25.8	57.3	12.4	1.1	100	
Literate/Primary	Count	1	35	151	88	0	275	
	%	0.4	12.7	54.9	32.0	0.0	100	
Lower Secondary	Count	1	8	60	32	0	101	
	%	1.0	7.9	59.4	31.7	0.0	100	
Secondary	Count	3	5	61	46	0	115	
	%	2.6	4.3	53.0	40.0	0.0	100	
Certificate Level/+2	Count	0	0	14	26	0	40	
	%	0.0	0.0	35.0	65.0	0.0	100	
Bachelor & above	Count	0	1	5	9	1	16	
	%	0.0	6.3	31.3	56.3	6.3	100	
Total	Count	8	72	342	212	2	636	
	%	1.3	11.3	53.8	33.3	0.3	100	

Source: Field Survey, 2015.

The table 7.33 shows that the majority of respondents (53.5%) were in the opinion of using clean blade and scissors to cut umbilical cord in home delivery and only 33.3% of respondents were found having knowledge about sterilization of blades, scissors or knives to cut umbilical cord in childbirth at home which is suitable for preventing from the infection and tetanus illness. The sterilization process could kill micro-organism. Age-wise, under 25 years respondents have higher percentage in the sterilization of blades or scissors for cutting umbilical cord. Education-wise, higher education level respondents gave the opinion of sterilized blades, scissors for cutting umbilical cord in childbirth in home.

The Chi-Square (χ^2) test shows that there was a significant association ($\chi^2 = 65.632$, $df = 20$ and $p = .000$, which is less than .05) found between the respondents of different *age-wise* groups in their perception on cutting the umbilical cord when giving birth at home. Similarly, there was a significant association ($\chi^2 = 89.780$, $df = 20$ and $p = .000$, which is less than .05) found between the respondents of different *education level-wise* groups in their perception on cutting umbilical cord when giving birth at home.

The occupation and marital status wise perception and association about the cutting umbilical cord in giving childbirth at home for maternal child health is presented in table 7.34:

Table 7.34: Perception on Cutting Umbilical Cord in Home-Delivery by Occupation and Marital Status

Occupation		Cutting Umbilical Cord after the Childbirth at Home					Total	Pearson Chi-Square
		Whatever Available	Clean Sickle/Small Sickle Knife	Clean Blade, Scissors	Sterilized Blade, Scissors	Fresh Split Cane (Choyān)		
Agriculture	Count	3	42	194	99	0	338	Asymp. Sig. (2-sided) .000
	%	0.9	12.4	57.4	29.3	0.0	100	
Job/ service in Nepal	Count	1	1	9	17	0	28	
	%	3.6	3.6	32.1	60.7	0.0	100	
Construction/ Maintenance Works	Count	1	3	7	9	0	20	
	%	5.0	15.0	35.0	45.0	0.0	100	
Business	Count	0	1	17	15	0	33	
	%	0.0	3.0	51.5	45.5	0.0	100	
Foreign Employment	Count	1	3	22	6	0	32	
	%	3.1	9.4	68.8	18.8	0.0	100	
Job in India	Count	0	2	15	6	0	23	
	%	0.0	8.7	65.2	26.1	0.0	100	
Housewife	Count	1	2	24	17	1	45	
	%	2.2	4.4	53.3	37.8	2.2	100	
Ex-Army/ Pensioner /Army in India or UK	Count	1	18	50	38	0	107	
	%	0.9	16.8	46.7	35.5	0.0	100	
Others	Count	0	0	4	5	1	10	
	%	0.0%	0.0	40.0	50.0	10.0	100	
Total	Count	8	72	342	212	2	636	
	%	1.3	11.3	53.8	33.3	0.3	100	

Marital Status								Asymp. Sig. (2- sided) .001
Married	Count	7	55	283	175	2	522	
	%	1.3	10.5	54.2	33.5	0.4	100	
Unmarried	Count	0	0	1	14	0	15	
	%	0.0	0.0	6.7	93.3	0.0	100	
Single (Widow/ Widower)	Count	1	17	57	23	0	98	
	%	1.0	17.3	58.2	23.5	0.0	100.0	
Divorced	Count	0	0	1	0	0	1	
	%	0.0	0.0	100	0.0	0.0	100	
Total	Count	8	72	342	212	2	636	
	%	1.3	11.3	53.8	33.3	0.3	100	

Source: Field Survey, 2015.

The table 7.34 shows respondents of jobs/services in Nepal were higher percentage in the opinion of using sterilized blade, scissors and marital status wise unmarried groups were higher percentage in the opinion of the using sterilized blade, scissors for cutting umbilical cord in giving birth at home.

The Chi-Square (χ^2) test shows that there was a significant association ($\chi^2 = 74.728$, $df = 32$ and $p = .000$, which is less than .05) found between the respondents of different *occupation* wise groups in their perception on cutting umbilical cord when giving birth at home. Similarly, there was a significant association ($\chi^2 = 32.306$, $df = 12$ and $p = .001$, which is less than .05) found between the respondents of different *marital status* wise groups in their perception on cutting umbilical cord when giving birth at home.

7.3.4 Likert Scale Distribution Regarding Perception of Modern MCH Care

In villages, there is a lack of services regarding modern maternal and child health (MCH) care due to several socio-economic constraints, poverty, rural area, unequal distribution of developments and so on. However, the publicity of modern maternal-child health care is increasing to the public in villages. The Likert Scale statements towards perceptions in modern maternal child health (MCH) care is presented in table 7.35:

Table 7.35: Likert Scale Statements on Perception towards Modern MCH Care

Statements	Agree		Uncertain		Disagree		Total	
	N	%	N	%	N	%	N	%
<i>D 21. Bleeding, abdomen pain, swelling body, fainting, etc complication occur in pregnancy should go to hospital immediately.</i>	580	91.2	53	8.3	3	0.5	636	100
<i>D 22. Hospital delivery is better than home delivery in child birth.</i>	598	94.0	33	5.2	5	0.8	636	100
<i>D 23. To prevent from diseases, infants should be vaccinated properly.</i>	324	50.9	296	46.6	16	2.5	636	100

Source: Field Survey, 2015.

The above three-degree scale responses Likert Scale statements about perceptions in modern maternal child health (MCH) care are analysed and the result is discussed as follows:

Here, according to Kothari and Garg (2015, pp 78-80), if the instruments consists 3 statements (Likert Scale questions) and three degrees, the following score value would be revealing:

3 x 3 = 9 most unfavourable responses

3 x 2 = 6 neural attitude

3 x 1 = 3 most favourable attitude.

Hence, here score for any individual would fall between 3 and 9. The score above 6; it shows that having low knowledge towards modern maternal child (MCH) care below 6 shows that having higher knowledge or inclination towards modern maternal child health (MCH) and exactly 6 is suggestive of neutral or undecided. The Likert Scale score distribution of perception towards modern maternal child health (MCH) care among the Magars is presented in table 6.36:

Table 7.36: Distribution of Likert Scale Score on Perception towards modern MCH Care

Score	Perception towards Modern MCH Care Services			
	Frequency	Percent	Valid Percent	Cumulative Percent
3.00	552	86.8	86.8	86.8
4.00	50	7.9	7.9	94.7
5.00	19	3.0	3.0	97.6
6.00	13	2.0	2.0	99.7
7.00	1	0.2	0.2	99.8
8.00	0	0.0	0.0	99.8
9.00	1	0.2	0.2	100.0
Total	636	100.0	100.0	

Source: Field Survey, 2015.

The table 7.36 shows, majority of respondents (86.8%) were more agreed with the Likert statements regarding modern MCH care and cumulatively 97.6% of respondents were agreed with the Likert statements regarding modern MCH care. The 2% of respondents were neutral. This indicates the awareness towards the use of modern maternal child health (MCH) care is increasing among the Magars, though there is a lack of facilities in local settings.

7.3.5 Knowledge about HIV/AIDS

HIV/AIDS is a burning issue in public health and maternal-child health. The infectious diseases caused by human immune deficiency virus (HIV) destroy the immune system of the body. In Nepal in FY 2071/72BS, 26,207 cases were recorded officially (DoHS, 2016,

p.179), however, unregistered PLHIV (People Living with HIV) might be hidden in society. The knowledge towards HIV/AIDS among the Magars is discussed here.

The age and sex-wise knowledge distribution and association of communicable illness HIV/AIDS among the Magar respondents are presented in table 7.37:

Table 7.37: Knowledge towards HIV/AIDS by Age and Sex

Age		Knowledge towards HIV/AIDS		Total	Pearson Chi-Square
		Known	Unknown		
Under 25	Count	40	0	40	Asymp. Sig. (2-sided) .000
	% within Age	100.0	0.0	100	
26 - 35	Count	124	5	129	
	% within Age	96.1	3.9	100	
36 - 45	Count	136	9	145	
	% within Age	93.8	6.2	100	
46 - 55	Count	103	27	130	
	% within Age	79.2	20.8	100	
56 - 65	Count	66	45	111	
	% within Age	59.5	40.5	100	
66 & above	Count	33	48	81	
	% within Age	40.7	59.3	100	
Total	Count	502	134	636	
	% within Age	78.9	21.1	100	
Sex					
Female	Count	239	79	318	Asymp. Sig. (2-sided) .020
	% within Sex	75.2	24.8	100	
Male	Count	263	55	318	
	% within Sex	82.7	17.3	100	
Total	Count	502	134	636	
	% within Sex	78.9	21.1	100	

Source: Field Survey, 2015.

The table 7.37 shows that, majority of Magar respondents (78.9%) were having knowledge about HIV/AIDS and 21.1% of respondents were unknown about HIV/AIDS. Age-wise, younger age groups had higher percentage in known about HIV/AIDS whereas older age groups had higher percentage of unknown about HIV/AIDS. Gender-wise, males were in higher percentage in known category than females.

The Chi-Square (χ^2) test shows that, there was a significant association ($\chi^2= 149.218$, $df = 5$ and $p = .000$, which is less than .05) found between the respondents of different age-wise groups in their knowledge on communicable disease HIV/AIDS. Similarly, there was a significant association ($\chi^2= 5.446$, $df = 1$ and $p = .020$, which is less than .05) found between the respondents of different sex-wise groups in their knowledge on communicable disease HIV/AIDS

The education and marital status wise knowledge and association of communicable illness HIV/AIDS among the Magar respondents is presented in table 7.38:

Table 7.38: Knowledge towards HIV/AIDS by Education and Marital Status

Education		Knowledge towards HIV/AIDS		Total	Pearson Chi-Square
		Known	Unknown		
Illiterate	Count	36	53	89	Asymp. Sig. (2-sided) .000
	% within Education	40.4	59.6	100	
Literate/ Primary	Count	203	72	275	
	% within Education	73.8	26.2	100	
Lower Secondary	Count	95	6	101	
	% within Education	94.1	5.9	100	
Secondary	Count	112	3	115	
	% within Education	97.4	2.6	100	
Certificate Level/+2	Count	40	0	40	
	% within Education	100.0	0.0	100	
Bachelor & above	Count	16	0	16	
	% within Education	100.0	0.0	100	
Total	Count	502	134	636	
	% within Education	78.9	21.1	100	
Marital Status					
Married	Count	433	89	522	Asymp. Sig. (2-sided) .000
	% within Marital Status	83.0	17.0	100	
Unmarried	Count	15	0	15	
	% within Marital Status	100.0	0.0	100	
Single (Widow/ Widower)	Count	53	45	98	
	% within Marital Status	54.1	45.9	100	
Divorced	Count	1	0	1	
	% within Marital Status	100.0	0.0	100	
Total	Count	502	134	636	
	% within Marital Status	78.9	21.1	100	

Source: Field Survey, 2015.

The table 7.38 shows that the respondents from the higher education level groups consisted of higher percentage having knowledge about HIV/AIDS but the respondents of lower education level groups were higher percentage in unknown about the HIV/AIDS. Marital status-wise respondents of unmarried groups have higher percentage in having knowledge towards HIV/AIDS and respondents of single (widow/ widowers) and married groups have higher percentage in unknown about the HIV/AIDS.

The Chi-Square (χ^2) test shows that, there was a significant association ($\chi^2= 135.987$, $df = 5$ and $p = .000$, which is less than .05) found between the respondents of different *education level*-wise groups in their knowledge on communicable disease HIV/AIDS. Similarly, there was a significant association ($\chi^2= 45.730$, $df = 3$ and $p = .000$, which is less than .05) found between the respondents of different *marital status* wise groups in their knowledge on communicable disease HIV/AIDS.

The occupation and types of family-wise knowledge and association of communicable illness HIV/AIDS among the Magar respondents are presented in table 7.39:

Table 7.39: Knowledge towards HIV/AIDS by Occupation and Types of Family

Occupation		Knowledge towards HIV/AIDS		Total	Pearson Chi-Square
		Known	Unknown		
Agriculture	Count	251	87	338	Asymp. Sig. (2-sided) .000
	% within Occupation	74.3	25.7	100	
Job/ Service in Nepal	Count	28	0	28	
	% within Occupation	100	0.0	100	
Construction/ Maintenance Works	Count	16	4	20	
	% within Occupation	80.0	20.0	100	
Business	Count	30	3	33	
	% within Occupation	90.9	9.1	100	
Foreign Employment	Count	32	0	32	
	% within Occupation	100	0.0	100	
Job in India	Count	21	2	23	
	% within Occupation	91.3	8.7	100	
Housewife	Count	43	2	45	
	% within Occupation	95.6	4.4	100	
Ex-Army/Pensioner/ Army in India or UK	Count	71	36	107	
	% within Occupation	66.4	33.6	100	
Others	Count	10	0	10	
	% within Occupation	100	0.0	100	
Total	Count	502	134	636	
	% within Occupation	78.9	21.1	100	
Types of Family					
Unitary	Count	235	43	278	Asymp. Sig. (2-sided) .002
	% within Types of Family	84.5	15.5	100	
Joint	Count	267	91	358	
	% within Types of Family	74.6	25.4	100	
Total	Count	502	134	636	
	% within Types of Family	78.9	21.1	100	

Source: Field Survey, 2015.

The table 7.39 shows that the respondents having occupation jobs/service in Nepal, foreign employment, other occupation (100%) and housewife were with higher percentage in having knowledge about HIV/AIDS. The respondents having occupation ex-army/pensioners, agriculture, construction/maintenance works were higher percentage in unknown category. The respondents of types of family-wise unitary type of family were higher percentage in having knowledge about the HIV/AIDS.

The Chi-Square (χ^2) test shows that, there was a significant association ($\chi^2 = 45.751$, $df = 8$ and $p = .000$, which is less than .05) found between the respondents of different *occupation* wise groups in their knowledge on communicable disease HIV/AIDS. Similarly, there was a significant association ($\chi^2 = 9.318$, $df = 1$ and $p = .002$, which is less than .05) found between the respondents of different *types of family*-wise groups in their knowledge on communicable disease HIV/AIDS.

7.3.6 Knowledge about Mode of Transmission of HIV/AIDS

HIV/AIDS is a communicable disease caused by the HIV virus. Globally, it is estimated that 34-46 million people are living with HIV/AIDS (WHO, 2008, p.7) and epidemiologists are keeping it into pandemic and it is lethal illness (Cockerham, 2012, p. 37). It is transmitted through sexual intercourses, body fluids, blood, using contaminated syringes, blades and sharp utensils. About the relation of HIV/AIDS and society Cockerham (2012) writes, "What makes AIDS a disease of society is that it is lodged into the conduct of social life and its influence on changing norms, values, sex habits, and lifestyle worldwide has been substantial" (p.37).

Proper knowledge and awareness about transmission of HIV/AIDS are helpful to prevention from transmission of one person to another of illness and it could reduce fear, stigma and discrimination surrounding HIV/AIDS in the community. The proper knowledge about the transmission of HIV/AIDS among the respondents is discussed here.

The age and education-wise knowledge and association towards the modes of transmission of HIV/AIDS is presented in table 7.40:

Table 7.40: Distribution of Knowledge in the Mode of Transmission of HIV/AIDS by Age and Education

Age		Knowledge in Mode of Transmission of HIV/AIDS					Total	Pearson Chi-Square
		Shaking hand	Sharing Leftover Food	Unsafe Sexual Intercourse	Unsafe Sex, Blood, Body Fluid, Injections	Don't Know		
Under 25	Count	0	0	6	34	0	40	Asymp . Sig. (2-sided) .000
	%	0.0	0.0	15.0	85.0	0.0	100	
26 - 35	Count	1	0	31	92	0	124	
	%	0.8	0.0	25.0	74.2	0.0	100	
36 - 45	Count	4	0	63	64	5	136	
	%	2.9	0.0	46.3	47.1	3.7	100	
46 - 55	Count	1	1	51	45	5	103	
	%	1.0	1.0	49.5	43.7	4.9	100	
56 - 65	Count	0	4	36	25	1	66	
	%	0.0	6.1	54.5	37.9	1.5	100	
66 & above	Count	1	2	20	8	2	33	
	%	3.0	6.1	60.6	24.2	6.1	100	
Total	Count	7	7	207	268	13	502	
	%	1.4	1.4	41.2	53.4	2.6	100	
Education Level								
Illiterate	Count	0	2	17	12	5	36	Asymp . Sig. (2-sided) .000
	%	0.0	5.6	47.2	33.3	13.9	100	
Literate/Primary	Count	5	5	106	79	8	203	
	%	2.5	2.5	52.2	38.9	3.9	100	
Lower Secondary	Count	1	0	48	46	0	95	
	%	1.1	0.0	50.5	48.4	0.0	100	
Secondary	Count	1	0	30	81	0	112	
	%	0.9	0.0	26.8	72.3	0.0	100	

Certificate Level/+2	Count	0	0	3	37	0	40
	%	0.0	0.0	7.5	92.5	0.0	100
Bachelor & above	Count	0	0	3	13	0	16
	%	0.0	0.0	18.8	81.3	0.0	100
Total	Count	7	7	207	268	13	502
	%	1.4	1.4	41.2	53.4	2.6	100

Source: Field Survey, 2015.

The table 7.40 shows that respondents of 53.4% had better knowledge about the mode of transmission of HIV/AIDS illness and 41.2% of respondents were told only unsafe sexual intercourse. The 1.4% of respondents were in confusion about the illness which will be transmitted through shaking hands, hugging, and another 1.4% of respondents were in confusion about the illness will transmitted through sharing leftover food with each other or sharing food on a common plate. Similarly, 2.6% of respondents fell into 'don't know' category about the mode of transmission of HIV/Illness but, they were claimed to know the illness.

Age-wise, younger age groups were found higher percentage in the mode of transmission through unsafe sex, body fluids, blood, contaminates syringes and sharp utensils. But older age groups were found in the mode of transmission through unsafe sexual intercourse only. Similarly, education-wise higher education level groups were found higher percentage mode of transmission through unsafe sex, body fluids, blood, contaminates syringes and sharp utensils.

The Chi-Square (χ^2) test shows that, there was a significant association ($\chi^2= 85.005$, $df = 20$ and $p = .000$, which is less than .05) found between the respondents of different *age*-wise groups in their knowledge on mode of transmission of communicable disease HIV/AIDS. Similarly, there was a significant association ($\chi^2= 98.352$, $df = 20$ and $p = .000$, which is less than .05) found between the respondents of different *education level*-wise groups in their knowledge on mode of transmission of communicable disease HIV/AIDS.

The occupation wise knowledge and association towards mode of transmission of HIV/AIDS is presented in table 7.41:

Table 7.41: Distribution of Knowledge in Mode of Transmission of HIV/AIDS by Occupation

Occupation		Knowledge in Mode of Transmission of HIV/AIDS					Total	Pearson Chi-Square
		Shaking hand	Sharing Leftover Food	Unsafe Sexual Intercourse	Unsafe Sex, Blood, Body Fluid, Injections	Don't Know		
Agriculture	Count	4	3	100	136	8	251	Asymp . Sig. (2-sided) .000
	%	1.6	1.2	39.8	54.2	3.2	100.0	
Job/ Service in Nepal	Count	1	0	1	26	0	28	
	%	3.6	0.0	3.6	92.9	0.0	100	
Construction/ Maintenance Works	Count	0	0	5	11	0	16	
	%	0.0	0.0	31.3	68.8	0.0	100	
Business	Count	0	0	12	18	0	30	
	%	0.0	0.0	40.0	60.0	0.0	100	
Foreign Employment	Count	1	0	14	17	0	32	
	%	3.1	0.0	43.8	53.1	0.0	100	
Job in India	Count	0	0	12	6	3	21	
	%	0.0	0.0	57.1	28.6	14.3	100	
Housewife	Count	0	0	18	25	0	43	
	%	0.0	0.0	41.9	58.1	0.0	100	
Ex-Army/ Pensioner/ Army in India or UK	Count	1	4	43	21	2	71	
	%	1.4	5.6	60.6	29.6	2.8	100	
Others	Count	0	0	2	8	0	10	
	%	0.0	0.0	20.0	80.0	0.0	100	
Total	Count	7	7	207	268	13	502	
	%	1.4	1.4	41.2	53.4	2.6	100	

Source: Field Survey, 2015.

The table 7.41 shows, the respondents having job/ service in Nepal occupations were higher percentage in mode of transmission through unsafe sex, body fluids, blood, contaminates syringes and sharp utensils.

The Chi-Square (χ^2) test shows that, there was a significant association ($\chi^2 = 70.328$, $df = 32$ and $p = .000$, which is less than .05) found between the respondents of different *occupation* wise groups in their knowledge on mode of transmission of communicable disease HIV/AIDS.

The age and education-wise knowledge and association towards mode of transmission of HIV/AIDS has presented in table 7.42:

Table 7.42: - Knowledge in Mode of Transmission of HIV/AIDS by Income Source

Income Source of Household		Knowledge in Mode of Transmission of HIV/AIDS					Total	Pears on Chi-Square
		Shaking hand	Sharing Leftover Food	Unsafe Sexual Intercourse	Unsafe Sex, Blood, Body Fluid, Injections	Don't Know		
Agriculture	Count	1	1	24	33	0	59	Asymp . Sig. (2-sided) .028
	%	1.7	1.7	40.7	55.9	0.0	100	
Agriculture, Labour or Wage's Works, Skill Works	Count	0	0	9	17	0	26	
	%	0.0	0.0	34.6	65.4	0.0	100	
Agriculture, Private Job in India or Equivalence	Count	0	0	31	14	6	51	
	%	0.0	0.0	60.8	27.5	11.8	100	
Agriculture, Business/ Small Entrepreneurships	Count	0	0	8	16	0	24	
	%	0.0	0.0	33.3	66.7	0.0	100	
Agriculture, Service/ Jobs in other Sectors	Count	0	0	9	6	1	16	
	%	0.0	0.0	56.3	37.5	6.3	100	
Agriculture, Teacher/Nepal Army/Police/Govt. Job/Pension	Count	0	0	14	36	1	51	
	%	0.0	0.0	27.5	70.6	2.0	100	
Other Sources not including Agriculture (e.g. Job, Foreign Employment, Business,etc)	Count	1	0	15	21	0	37	
	%	2.7	0.0	40.5	56.8	0.0	100	
Agriculture, Foreign Employment (Gulf, Malaysia or Equivalent)	Count	2	2	38	53	2	97	
	%	2.1	2.1	39.2	54.6	2.1	100	
Agriculture, Indian Army/Police or Pension	Count	2	4	53	56	3	118	
	%	1.7	3.4	44.9	47.5	2.5	100	
Agriculture, Foreign Employment (Korea, Afghanistan, Iraq, Europe, America or equivalent)	Count	1	0	4	11	0	16	
	%	6.3	0.0	25.0	68.8	0.0	100	
Agriculture, British Army/Singapore Police or Pension	Count	0	0	2	5	0	7	
	%	0.0	0.0	28.6	71.4	0.0	100	
Total	Count	7	7	207	268	13	502	
	%	1.4	1.4	41.2	53.4	2.6	100	

Source: Field Survey, 2015.

The table 7.42 shows that, the Chi-Square (χ^2) test shows that, there was a significant association ($\chi^2= 58.862$, $df = 40$ and $p = .028$, which is less than .05) found between the respondents of different *income source of household* wise groups in their knowledge on mode of transmission of communicable disease HIV/AIDS.

7.4 Beliefs on Drugs and Side Effects of Medicine

7.4.1 Belief on Effectiveness of Herbs and Shrubs (Traditional Drugs)

Traditional medicine such as herbs and shrubs and other ingredients of healing drugs prepared from the traditional healers are practiced in the Magars. The result of beliefs on traditional medicines is discussed and presented in table 7.43:

Table 7.43: Beliefs on Effectiveness of Traditional Medicine in Healing for Illness

VDC		Effectiveness of Traditional Medicines				Total	Pearson Chi-Square
		Most of illness can be healed	Some illness can be healed	No belief	Don't know		
Alamdevi	Count	16	65	2	4	87	Asymp. Sig. (2-sided) .000
	%	18.4	74.7	2.3	4.6	100	
Birgha	Count	6	51	7	0	64	
	%	9.4	79.7	10.9	0.0	100	
ChandiBhanjyang	Count	6	66	3	5	80	
	%	7.5	82.5	3.8	6.3	100	
Jagatradevi	Count	4	102	8	8	122	
	%	3.3	83.6	6.6	6.6	100	
Malungga	Count	5	15	6	1	27	
	%	18.5	55.6	22.2	3.7	100	
Nibuwakharka	Count	3	45	5	4	57	
	%	5.3	78.9	8.8	7.0	100	
Pelakot	Count	7	34	10	3	54	
	%	13.0	63.0	18.5	5.6	100	
Pindikhola	Count	6	27	1	3	37	
	%	16.2	73.0	2.7	8.1	100	
Shree Krishna Gandaki	Count	25	67	10	6	108	
	%	23.1	62.0	9.3	5.6	100	
Total	Count	78	472	52	34	636	
	%	12.3	74.2	8.2	5.3	100	

Source: Field Survey, 2015.

The table 7.43 shows that the majority of respondents (74.2%) told traditional medicine can cure some illness, 12.3% of respondents opined that most of illness can be cured and 8.2% respondents found no belief in the effectiveness of traditional drugs. VDC-wise, the respondents of Jagatradevi (83.6%), Birgha (79.7%), Nibuwakharka (78.9%) were higher percentage in response of some illness could be cured by traditional medicine.

The Chi-Square (χ^2) test shows that, there was a significant association ($\chi^2 = 60.292$, $df = 24$ and $p = .000$, which is less than .05) found between the respondents of different VDC wise groups in their belief on effectiveness of traditional medicines.

7.4.2 Likert Scale Distribution on Beliefs in Traditional Healing

In the Magar villages, there are still practices of shaman, medicinal herbs and shrubs, faith and cultural healings, healing through priests and shrines, worships, etc. for healings. The local people or healers could recognize local medicinal herbs and shrubs and their uses, local illnesses. The belief on traditional healings three Likert Scale statements is given in below:

Table 7.44: Likert Scale Statements about Belief in Traditional Healings

Statements	Agree		Uncertain		Disagree		Total	
	N	%	N	%	N	%	N	%
<i>D12. Local illness (e.g. beggar, ganogola, kufat, sul, lagobhago, etc) can be identified or diagnosed better by the shamans/traditional healers (lama) than the doctor.</i>	215	33.8	344	54.1	77	12.1	636	100
<i>D 13. Traditional healer shamans (Lama) are able to cure common local illness or specific local illness.</i>	283	44.5	308	48.4	45	7.1	636	100
<i>D 16. Correctly use of medicinal herbs and shrubs which were used by the Magar ancestors can cure the diseases.</i>	456	71.7	162	25.5	18	2.8	636	100

Source: Field Survey, 2015

The above three-degree scale responses Likert Scale statements on belief on traditional healings are analysed and the result is discussed as follows:

According to Kothari and Garg (2015, pp 78-80), if the instruments consists 3 statements (Likert Scale questions) and three degrees, the following score value would be revealing:

3 x 3 = 9 Most of unbelief attitudes

3 x 2 = 6 neural attitude

3 x 1 = 3 Most of belief responses

Hence, here score for any individual would fall between 3 and 9. The score above 6; it shows having no belief and a score below 6 shows that having belief in traditional healings and exactly 6 is suggestive of neutral or undecided. The Likert scale score distribution of beliefs on traditional healings among the Magars is presented in table 7.45:

Table 7.45: Distribution of Likert Scale Score on Beliefs in Traditional Healings

Score	Belief on Traditional Healings			
	Frequency	Percent	Valid Percent	Cumulative Percent
3.00	150	23.6	23.6	23.6
4.00	120	18.9	18.9	42.5
5.00	198	31.1	31.1	73.6
6.00	114	17.9	17.9	91.5
7.00	40	6.3	6.3	97.8
8.00	8	1.3	1.3	99.1
9.00	6	0.9	0.9	100.0
Total	636	100.0	100.0	

Source: Field survey, 2015.

The table 7.45 shows that the respondents of 23.6% were found extremely believing on traditional healings and cumulatively 73.6% were had their belief on traditional healings. The 0.9% respondents were found extremely not believing and cumulatively 2.2% respondents have no belief on traditional healings. Further, 17.9% of respondents remained undecided. This indicates the Magars have a belief on their own traditional medication and healing practices yet.

7.4.3 Belief on Effectiveness of Allopathic Medicines

Western medicine (allopathic) is spread out all over the Magar villages and they are dependent on using it. The result of their belief on the effectiveness of allopathic medicine in healing is discussed here.

The age and marital status-wise distribution and association of belief on effectiveness of allopathic medicines in healing for illness of Magars are presented in table 7.46:

Table 7.46: Beliefs on Effectiveness of Allopathic Medicine in Healing for Illness by Age and Marital Status

Age		Effectiveness of Allopathic Medicines				Total	Pearson Chi-Square
		Most of diseases can be cured	Some diseases can be cured	No belief	Don't Know		
Under 25	Count	16	18	3	3	40	Asymp. Sig. (2-sided) .019
	%	40.0	45.0	7.5	7.5	100	
26 -35	Count	78	44	2	5	129	
	%	60.5	34.1	1.6	3.9	100	
36 -45	Count	89	46	3	7	145	
	%	61.4	31.7	2.1	4.8	100	
46 -55	Count	75	47	1	7	130	
	%	57.7	36.2	0.8	5.4	100	
56 - 65	Count	63	31	1	16	111	
	%	56.8	27.9	0.9	14.4	100	
66 & above	Count	49	21	3	8	81	
	%	60.5	25.9	3.7	9.9	100	
Total	Count	370	207	13	46	636	
	%	58.2	32.5	2.0	7.2	100	
Marital Status							Asymp. Sig. (2-sided) .018
Married	Count	299	179	7	37	522	
	%	57.3	34.3	1.3	7.1	100	
Unmarried	Count	9	4	2	0	15	
	%	60.0	26.7	13.3	0.0	100	
Single (Widow/ Widower)	Count	62	23	4	9	98	
	%	63.3	23.5	4.1	9.2	100	
Divorced	Count	0	1	0	0	1	
	%	0.0	100.0	0.0	0.0	100	
Total	Count	370	207	13	46	636	
	%	58.2	32.5	2.0	7.2	100	

Source: Field survey, 2015.

The table 7.46 shows that majority of the respondents (Most of the diseases can be cured 58.2% and some diseases can be cured 32.5%) were found having a belief on allopathic medicine, but 7.2% of respondent have no idea about the effectiveness of allopathic medicine and 2% respondents were not believing in the effectiveness of allopathic drugs. The age-wise, 36-45 years age groups (61.4%) and marital status-wise, single (widow/widower) (63.3%) were in higher percentage in the effectiveness of most of diseases can be cured by allopathic medicine.

The Chi-Square (χ^2) test shows that, there was a significant association ($\chi^2= 28.433$, $df = 15$ and $p = .019$, which is less than .05) found between the respondents of different *age-wise* groups in their belief on the effectiveness of allopathic medicines. Similarly, there was a significant association ($\chi^2= 19.993$, $df = 9$ and $p = .018$, which is less than .05) found between the respondents of different *marital status* wise groups in their belief on effectiveness of allopathic medicines.

The VDC-wise distribution and association of belief on effectiveness of allopathic medicines in healing for illness of Magars are presented in table 7.47:

Table 7.47: Beliefs on Effectiveness of Allopathic Medicine in Healing for Illness

VDC		Effectiveness of Allopathic Medicines				Total	Pearson Chi-Square
		Most of diseases can be cured	Few diseases can be cured	No belief	Don't Know		
Alamdevi	Count	58	23	1	5	87	Asymp. Sig. (2-sided) .017
	%	66.7	26.4	1.1	5.7	100	
Birgha	Count	33	26	5	0	64	
	%	51.6	40.6	7.8	0.0	100	
ChandiBhanjyag	Count	49	24	1	6	80	
	%	61.3	30.0	1.3	7.5	100	
Jagatradevi	Count	77	32	1	12	122	
	%	63.1	26.2	0.8	9.8	100	
Malungga	Count	17	6	0	4	27	
	%	63.0	22.2	0.0	14.8	100	
Nibuwakharka	Count	37	16	0	4	57	
	%	64.9	28.1	0.0	7.0	100	
Pelakot	Count	27	20	1	6	54	
	%	50.0	37.0	1.9	11.1	100	
Pindikhola	Count	21	13	0	3	37	
	%	56.8	35.1	0.0	8.1	100	
Shree Krishna Gandaki	Count	51	47	4	6	108	
	%	47.2	43.5	3.7	5.6	100	
Total	Count	370	207	13	46	636	
	%	58.2	32.5	2.0	7.2	100	

Source: Field Survey, 2015.

The table 7.47 shows, the respondents of VDC-wise, Alamdevi (66.7%) and Nibuwakharka (64.9%) were in higher percentage in belief on most of the diseases can be cured by allopathic medicine.

The Chi-Square (χ^2) test shows that, there was a significant association ($\chi^2= 40.806$, $df = 24$ and $p = .017$, which is less than .05) found between the respondents of different VDC wise groups in their belief on the effectiveness of allopathic medicines.

7.4.4 Knowledge towards Side Effects of Medicines

Allopathic medicines could produce adverse effects when administered in the human body. It is also called side effects or unwanted effects. Self-medication, misuse of drugs, wrong practice of drugs could be harmful to patients. Therefore, only the registered medical practitioners or health workers are eligible to prescribe medicines that are regulated through the country and WHO. The knowledge and awareness about the side effects of allopathic medicine among the Magars are discussed here.

The age and sex-wise distribution and association of knowledge and awareness about the side effects of allopathic medicine of respondents are presented in table 7.48:

Table 7.48: Knowledge towards Side Effects of Allopathic Medicine by Age and Sex

Age		Responses			Total	Pearson Chi-Square
		Well Known	Heard only	Don't Know		
Under 25	Count	17	18	5	40	Asymp. Sig. (2-sided) .000
	% within Age	42.5	45.0	12.5	100	
26 - 35	Count	31	63	35	129	
	% within Age	24.0	48.8	27.1	100	
36 - 45	Count	37	72	36	145	
	% within Age	25.5	49.7	24.8	100	
46 - 55	Count	25	66	39	130	
	% within Age	19.2	50.8	30.0	100	
56 - 65	Count	15	52	44	111	
	% within Age	13.5	46.8	39.6	100	
66 & above	Count	11	29	41	81	
	% within Age	13.6	35.8	50.6	100	
Total	Count	136	300	200	636	
	% within Age	21.4	47.2	31.4	100	
Sex						
Female	Count	54	158	106	318	Asymp. Sig. (2-sided) .040
	% within Sex	17.0	49.7	33.3	100	
Male	Count	82	142	94	318	
	% within Sex	25.8	44.7	29.6	100	
Total	Count	136	300	200	636	
	% within Sex	21.4	47.2	31.4	100	

Source: Field Survey, 2015.

The table 7.48 shows that the respondents of 47.2% responded as heard only, 31.4% respondents were unknown and only 21.4% were aware of the side effect of allopathic medicines. Age-wise, younger age groups were found having the knowledge about the side effect of medicine and sex-wise, male were found having knowledge about the side effect of medicine than females.

The Chi-Square (χ^2) test shows that, there was a significant association ($\chi^2= 37.883$, $df = 10$ and $p = .000$, which is less than .05) found between the respondents of different *age-wise* groups in their knowledge on side effects of allopathic medicines. Similarly, there was a significant association ($\chi^2= 7.338$, $df = 2$ and $p = .026$, which is less than .05) found between the respondents of different *sex-wise* groups in their knowledge on side effects of allopathic medicines.

The Education and Marital Status wise distribution, association of knowledge and awareness about the side effects of allopathic medicine of respondents are presented in table 7.49:

Table 7.49: Knowledge towards Side Effects of Allopathic Medicine by Education and Marital Status

Education Level		Responses			Total	Pearson Chi-Square
		Well Known	Heard only	Don't Know		
Illiterate	Count	8	37	44	89	Asymp. Sig. (2-sided) .000
	% within Education	9.0	41.6	49.4	100	
Literate/Primary	Count	46	135	94	275	
	% within Education	16.7	49.1	34.2	100	
Lower Secondary	Count	25	49	27	101	
	% within Education	24.8	48.5	26.7	100	
Secondary	Count	30	62	23	115	
	% within Education	26.1	53.9	20.0	100	
Certificate Level/+2	Count	18	15	7	40	
	% within Education	45.0	37.5	17.5	100	
Bachelor & above	Count	9	2	5	16	
	% within Education	56.3	12.5	31.3	100	
Total	Count	136	300	200	636	
	% within Education	21.4	47.2	31.4	100	
Marital Status						
Married	Count	117	252	153	522	Asymp. Sig. (2-sided) .001
	% within Marital Status	22.4	48.3	29.3	100	
Unmarried	Count	8	3	4	15	
	% within Marital Status	53.3	20.0	26.7	100	
Single (Widow/Widower)	Count	11	44	43	98	
	% within Marital Status	11.2	44.9	43.9	100	
Divorced	Count	0	1	0	1	
	% within Marital Status	0.0	100	0.0	100	
Total	Count	136	300	200	636	
	% within Marital Status	21.4	47.2	31.4	100	

Source: Field Survey, 2015.

The table 7.49 shows that, the respondents having higher education level were found to a higher percentage in having knowledge and awareness towards side effects of allopathic medicines and unmarried respondents were found higher percentage in having knowledge and awareness towards side effects of allopathic medicines.

The Chi-Square (χ^2) test shows that, there was a significant association ($\chi^2= 55.056$, $df = 10$ and $p = .000$, which is less than .05) found between the respondents of different *education level*-wise groups in their knowledge on side effects of allopathic medicines. Similarly, there was a significant association ($\chi^2= 21.542$, $df = 6$ and $p = .001$, which is less than .05) found between the respondents of different *marital status* wise groups in their knowledge on side effects of allopathic medicines.

The occupation-wise distribution and association of knowledge and awareness about the side effects of allopathic medicine of respondents are presented in table 7.50:

Table 7.50: Knowledge towards Side Effects of Allopathic Medicine by Occupation

Occupation		Responses			Total	Pearson Chi-Square
		Well Known	Heard only	Don't Know		
Agriculture	Count	57	163	118	338	Asymp. Sig. (2-sided) .000
	% within Occupation	16.9	48.2	34.9	100	
Job/ Service in Nepal	Count	13	8	7	28	
	% within Occupation	46.4	28.6	25.0	100	
Construction/ Maintenance Works	Count	4	12	4	20	
	% within Occupation	20.0	60.0	20.0	100	
Business	Count	12	16	5	33	
	% within Occupation	36.4	48.5	15.2	100	
Foreign Employment	Count	8	20	4	32	
	% within Occupation	25.0	62.5	12.5	100	
Job in India	Count	5	13	5	23	
	% within Occupation	21.7	56.5	21.7	100	
Housewife	Count	14	20	11	45	
	% within Occupation	31.1	44.4	24.4	100	
Ex-Army/ Pensioner/ Army in India or UK	Count	17	44	46	107	
	% within Occupation	15.9	41.1	43.0	100	
Others	Count	6	4	0	10	
	% within Occupation	60.0	40.0	0.0	100	
Total	Count	136	300	200	636	
	% within Occupation	21.4	47.2	31.4	100	

Source: Field Survey, 2015.

The table 7.50 shows that the respondents having other occupations and job/ service in Nepal were found to a higher percentage in having knowledge and respondents having construction works, foreign employments had a higher percentage in heard only about the knowledge of side effects of the allopathic drugs.

The Chi-Square (χ^2) test shows that, there was a significant association ($\chi^2= 49.473$, $df = 16$ and $p = .000$, which is less than .05) found between the respondents of different *occupation* wise groups in their knowledge on side effects of allopathic medicines.

7.4.5 Likert Scale Distribution of Going into Modern Health Care System

In the villages, many people do not go to health institutions when they become ill rather depend on traditional healings, self-medication (allopathic). They go in into such institutions at the late stage of illness which can become complicated and risky to the patients. It is due to several social causes such as socio-economic constraints, far distance, low awareness, health worker's behaviours, etc. The Likert Scale statements are given in table 7.51:

Table 7.51: Likert Scale Statements about Going into Modern Health Care System

Statements	Agree		Uncertain		Disagree		Total	
	N	%	N	%	N	%	N	%
<i>D 17. It is better to go health post, hospital or doctor's clinic when suffering from an illness or disease.</i>	529	83.2	67	10.5	40	6.3	636	100
<i>D 18. Medicine can be administered without a doctor or health worker's prescription could be harmful</i>	90	14.2	120	18.8	426	67	636	100

Source: Field Survey, 2015

The above three-degree response Likert scale statements about the perception to avoid self-medication in going modern health institutions when falling illness are analysed and the result is discussed as follows:

According to Kothari and Garg (2015, pp 78-80), if the instruments consists 2 statements (Likert Scale questions) and three degrees, the following score value would be revealing:

2 x 3 = 6 Most of unfavourable attitudes;

2 x 2 = 4 neural attitude;

2 x 1 = 2 Most of favourable responses,

Hence, here score for any individual would fall between 2 and 6. The score above 4; it shows that having negative perception and the score below 4 shows that having a positive perception towards avoiding self-medication and going into modern health institutions, and exactly 4 is suggestive of neutral or undecided. The Likert scale score distribution of perceptions towards avoiding self-medication and going into modern health care systems among the Magars is presented in table 7.52:

Table 7.52: Distribution of Likert Scale Score on Perception towards Avoiding Self-medication and going to Modern Health Care System

Score	Avoiding Self-medication and Going Health Institutions			
	Frequency	Percent	Valid Percent	Cumulative Percent
2.00	386	60.7	60.7	60.7
3.00	102	16.0	16.0	76.7
4.00	109	17.1	17.1	93.9
5.00	29	4.6	4.6	98.4
6.00	10	1.6	1.6	100.0
Total	636	100.0	100.0	

Source: Field Survey, 2015.

The table 7.52 shows that the respondents of 60.7% were found highly positive responses to avoiding self-medication and going to health institutions in falling illness. Cumulatively 76.7% of respondents were found agreed to the Likert statements and 17.1% of respondents were neutral or undecided to avoiding self-medication and going to health institutions in falling illness. The 6.2% of respondents were found disagreed with the statements avoiding self-medication and going to health institutions in falling illness. This indicates that awareness about self-medication practice and early go the health institution when fall in illness is found increasing among the Magars of the study area.

7.5 Perception towards Some Magar Traditional Cultural Practices

7.5.1 Perception on Culture of Sprinkling Alcohol at God-than/shrine in Worship

In traditional Magar culture, the Magars sprinkle alcohol (liquor) on god-thān/ shrine made by themselves in worshipping time or offers to gods. Scientifically alcohol is an antiseptic and kills the micro-organism. It has properties of solvent, pain killer, fuel and so on; but misuse of it creates addiction. However, in Magar culture, it gets priority. Here, responses of the Magars about alcohol using in god-thān/ shrine discussed.

The age and education-wise perception and association towards sprinkling alcohol (liquor) at god-thān or shrine at worshipping are presented in table 7.53:

Table 7.53: Perception on Culture of Alcohol Sprinkling by Age and Education

Age		Response						Total	Pearson Chi-Square
		To kill micro-organism / insects	To banish evil spirit	To please God, Goddess, Godlings	Traditional custom	No allow due to religion	Don't Know		
Under 25	Count	5	0	6	19	0	10	40	Asymp. Sig. (2-sided) .040
	%	12.5	0.0	15.0	47.5	0.0	25.0	100	
26 - 35	Count	18	5	20	68	0	18	129	
	%	14.0	3.9	15.5	52.7	0.0	14.0	100	
36 - 45	Count	16	9	38	67	1	14	145	
	%	11.0	6.2	26.2	46.2	0.7	9.7	100	
46 - 55	Count	18	7	25	68	0	12	130	
	%	13.8	5.4	19.2	52.3	0.0	9.2	100	
56 - 65	Count	11	11	32	53	0	4	111	
	%	9.9	9.9	28.8	47.7	0.0	3.6	100	
66 & above	Count	12	7	22	35	0	5	81	
	%	14.8	8.6	27.2	43.2	0.0	6.2	100	
Total	Count	80	39	143	310	1	63	636	
	%	12.6	6.1	22.5	48.7	0.2	9.9	100	
Education Level									
Illiterate	Count	12	9	24	37	0	7	89	Asymp. Sig. (2-sided) .000
	%	13.5	10.1	27.0	41.6	0.0	7.9	100	
Literate/ Primary	Count	28	21	73	129	0	24	275	
	%	10.2	7.6	26.5	46.9	0.0	8.7	100	
Lower Secondary	Count	18	7	14	55	0	7	101	
	%	17.8	6.9	13.9	54.5	0.0	6.9	100	
Secondary	Count	9	1	23	67	0	15	115	
	%	7.8	0.9	20.0	58.3	0.0	13	100	
Certificate Level/+2	Count	10	0	6	15	1	8	40	
	%	25.0	0.0	15.0	37.5	2.5	20	100	
Bachelor & above	Count	3	1	3	7	0	2	16	
	%	18.8	6.3	18.8	43.8	0.0	12.5	100	
Total	Count	80	39	143	310	1	63	636	
	%	12.6	6.1	22.5	48.7	0.2	9.9	100	

Source: Field Survey, 2015.

The table 7.53 shows that, the respondents 48.7% perceived as traditional custom and 22.5% of respondents took as to please the god, goddess or godlings. The 6.1% of respondents told to banish evil spirits in the god-thān/ shrine. Hence, about the culture of sprinkling alcohol (liquor) at god-thān/ shrine, the majority of respondents had understood it as a traditional culture only. The 12.6% of respondents were percept that the traditional custom was for killing micro-organism at the shrine and for cleaning the shrine.

Age-wise, the respondents having middle old age groups were found higher percentage in percept as traditional custom and education-wise, lower secondary and secondary level groups were found higher percentage in the perception of traditional custom about the cultural practice of sprinkling liquor at god shrine in worshipping.

The Chi-Square (χ^2) test shows that there was a significant association ($\chi^2= 38.588$, $df = 25$ and $p = .040$, which is less than .05) found between the respondents of different *age-wise* groups in their perception on alcohol sprinkling traditional culture at god-thān/ shrine. Similarly, there was a significant association ($\chi^2= 56.597$, $df = 25$ and $p = .000$, which is less than .05) found between the respondents of different *education level-wise* groups in their perception on alcohol sprinkling traditional culture at god-thān/ shrine.

7.5.2 Perception on Using *Titepāti* in Worship and Rituals

A bitter plant *Titepāti* (wormwood/mugwort) is a medicinal plant and which is found in hilly regions and Magars called Pātisār. The Magars used it in the worshipping, life cycle rituals and cultural performances, and has great value in Magars, as like *Tulasi* (basil) plant among the Brahman, and Chhetri. In Badā Dashain festival, Magars use *Titepāti flower* and leaves with Jamarā in Dashain Tikā festival. The belief and perception in the culture of *Titepāti plant* among the Magars are discussed here.

The religion and language-wise distribution and association of perception of respondents towards cultural use of *Titepāti* (Pātisār) plant are presented in table 7.54:

Table 7.54: Perception toward Using *Titepāti* (Pātisār) in Culture by Religion and Language

Religion		Response					Total	Pearson Chi-Square
		Being medicinal/ ritually pure herb	Being smell to chase insects	Traditional customs	To please God, Goddess /Godlings	Don't Know		
Traditional or Animist	Count	37	17	88	2	2	146	Asymp. Sig. (2-sided) .034
	%	25.3	11.6	60.3	1.4	1.4	100	
Buddhist	Count	11	17	53	1	3	85	
	%	12.9	20.0	62.4	1.2	3.5	100	
Hindu	Count	85	32	216	8	15	356	
	%	23.9	9.0	60.7	2.2	4.2	100	
Christian	Count	1	1	3	1	1	7	
	%	14.3	14.3	42.9	14.3	14.3	100	

Atheism/ Nastik	Count	1	1	0	0	0	2	Asymp. Sig. (2- sided) .042	
	%	50.0	50.0	0.0	0.0	0.0	100		
Don't Know	Count	14	4	22	0	0	40		
	%	35.0	10.0	55.0	0.0	0.0	100		
Total	Count	149	72	382	12	21	636		
	%	23.4	11.3	60.1	1.9	3.3	100		
Language									
Magar	Count	142	69	366	11	17	605		Asymp. Sig. (2- sided) .042
	%	23.5	11.4	60.5	1.8	2.8	100		
Nepali	Count	7	3	16	1	4	31		
	%	22.6	9.7	51.6	3.2	12.9	100		
Total	Count	149	72	382	12	21	636		
	%	23.4	11.3	60.1	1.9	3.3	100		

Source: Field Survey, 2015.

The table 7.54 shows that the majority of respondents (60.1%) were percept as only traditional customs about the use of Titepāti (Pātisār) plant in worship and cultural performances. Respondents of 23.4% known as a medicinal plant and ritually pure plant and 11.3% respondents known as the smell could chase away the microbes or harmful insects. Religion wise traditional or animist, Buddhist and Hindu respondents were higher percentage in traditional custom and respondents of Magar language speakers were higher percentage in traditional custom about use of Titepāti (Pātisār) plant in worship and cultural performances.

The Chi-Square (χ^2) test shows that there was a significant association ($\chi^2= 33.020$, $df = 20$ and $p = .034$, which is less than .05) found between the respondents of different *religion*-wise groups in their perception on using Titepāti (Pātisār) plant in worshipping of god/goddess, godlings and life cycle ritual and cultural performances. Similarly, there was a significant association ($\chi^2= 9.883$, $df = 4$ and $p = .042$, which is less than .05) found between the respondents of different *language*-wise groups in their perception on using Titepāti (Pātisār) plant in worshipping of god/goddess, godlings and life cycle ritual and cultural performances.

7.5.3 Perception on Putting Tikā on Forehead of Baby in Carrying Outside

In the villages of Nepal, when a baby or child carrying outside from home; or in the evening time; they put the tikā of turmeric or ash or charcoal on the forehead of the child. The views of Magar respondents in doing such culture among the Magar villages are discussed here.

The age and sex-wise distribution of perception of respondents about the putting *tikā* of turmeric or ash or charcoal on the forehead of the baby in walking away from the home or in walking in the evening time is presented in table 7.55:

Table 7.55: Perception about Putting *tikā* on the Forehead of a Baby in Talikng or Walking Outside by Age and Sex

Age		Responses						Total	Pearson Chi-Square	
		Prevent from evil-spirit	Wishing not become ill	Being traditional custom	Superstition	We don't due to our religion	Don't Know			
Under 25	Count	16	3	15	2	1	3	40	Asymp. Sig. (2-sided) .011	
	%	40.0	7.5	37.5	5.0	2.5	7.5	100		
26 - 35	Count	65	14	40	7	1	2	129		
	%	50.4	10.9	31.0	5.4	0.8	1.6	100		
36 - 45	Count	81	28	28	6	0	2	145		
	%	55.9	19.3	19.3	4.1	0.0	1.4	100		
46 - 55	Count	73	19	30	6	0	2	130		
	%	56.2	14.6	23.1	4.6	0.0	1.5	100		
56 - 65	Count	62	23	23	2	1	0	111		
	%	55.9	20.7	20.7	1.8	0.9	0.0	100		
66 & above	Count	53	13	15	0	0	0	81		
	%	65.4	16.0	18.5	0.0	0.0	0.0	100		
Total	Count	350	100	151	23	3	9	636		
	%	55.0	15.7	23.7	3.6	0.5	1.4	100		
Sex										
Female	Count	182	53	74	3	2	4	318		Asymp. Sig. (2-sided) .016
	%	57.2	16.7	23.3	0.9	0.6	1.3	100		
Male	Count	168	47	77	20	1	5	318		
	%	52.8	14.8	24.2	6.3	0.3	1.6	100		
Total	Count	350	100	151	23	3	9	636		
	%	55.0	15.7	23.7	3.6	0.5	1.4	100		

Source: Field survey, 2015.

The table 7.55 shows the majority of respondents (55%) were found having an opinion on prevent from evil-spirit, and 15.7% of respondents were having an opinion on wishing for good health, 23.7% respondents gave opinion of traditional custom and only 3.6% respondents gave their opinion of superstition. The respondents of older age groups were higher percentage in the opinion of preventing from evil-spirit and sex-wise female were higher percentage in opinion of preventing form evil-spirit about the culture of putting *tikā* of turmeric or ash or charcoal on the forehead of a baby before leaving home to go away.

The Chi-Square (χ^2) test shows that there was a significant association ($\chi^2= 44.020$, $df = 25$ and $p = .011$, which is less than .05) found between the respondents of different *age*-wise groups in their perception on putting *tikā* of turmeric or ash or charcoal on the forehead of a baby before leaving home and going outside. Similarly, there was a significant association ($\chi^2= 13.989$, $df = 5$ and $p = .016$, which is less than .05) found between the respondents of different *sex*-wise groups in their perception on putting *tikā* of turmeric or ash or charcoal on the forehead of a baby before leaving home and going outside.

The education level and religion-wise distribution of perception and association about the putting *tikā* of turmeric or ash or charcoal on the forehead of a baby in walking away from the home or in walking in the evening time is presented in table 7.56:

Table 7.56: Perception about Putting Tikā on Forehead of Baby in Walking or Taking Outside by Education and Religion

Education Level		Response						Total	Pearson Chi-Square	
		Prevent from evil-spirit	Wishing not become illness	Being traditional custom	Supers tition	We don't due to our religion	Don't Know			
Illiterate	Count	58	15	15	0	0	1	89	Asymp. Sig. (2-sided) .011	
	%	65.2	16.9	16.9	0.0	0.0	1.1	100		
Literate/ Primary	Count	152	50	66	5	1	1	275		
	%	55.3	18.2	24.0	1.8	0.4	0.4	100		
Lower Secondary	Count	52	13	28	7	0	1	101		
	%	51.5	12.9	27.7	6.9	0.0	1.0	100		
Secondary	Count	59	16	27	9	1	3	115		
	%	51.3	13.9	23.5	7.8	0.9	2.6	100		
Certificate Level/+2	Count	19	3	12	2	1	3	40		
	%	47.5	7.5	30.0	5.0	2.5	7.5	100		
Bachelor & above	Count	10	3	3	0	0	0	16		
	%	62.5	18.8	18.8	0.0	0.0	0.0	100		
Total	Count	350	100	151	23	3	9	636		
	%	55.0	15.7	23.7	3.6	0.5	1.4	100		
Religion										
Traditional or Animist	Count	67	31	41	5	0	2	146		Asymp. Sig. (2-sided) .000
	%	45.9	21.2	28.1	3.4	0.0	1.4	100		
Buddhist	Count	48	15	19	2	0	1	85		
	%	56.5	17.6	22.4	2.4	0.0	1.2	100		
Hindu	Count	211	46	79	14	1	5	356		
	%	59.3	12.9	22.2	3.9	0.3	1.4	100		
Christian	Count	2	1	2	0	2	0	7		
	%	28.6	14.3	28.6	0.0	28.6	0.0	100		
Atheism/ Nastik	Count	1	0	1	0	0	0	2		
	%	50.0	0.0	50.0	0.0	0.0	0.0	100		
Don't Know	Count	21	7	9	2	0	1	40		
	%	52.5	17.5	22.5	5.0	0.0	2.5	100		
Total	Count	350	100	151	23	3	9	636		
	%	55.0	15.7	23.7	3.6	0.5	1.4	100		

Source: Field Survey, 2015.

The table 7.56 shows, the illiterate respondents (65.2%) had higher percentage in the opinion on preventing from the evil spirit and religion-wise, the respondents of Hindu (56.5%) were in higher percentage in the opinion on preventing from evil spirit about putting *tikā* of turmeric or ash or charcoal on the forehead of a baby before leaving home to go away.

The Chi-Square (χ^2) test shows that there was a significant association ($\chi^2= 44.024$, $df = 25$ and $p = .011$, which is less than .05) found between the respondents of different education level groups in their perception on putting *tikā* of turmeric or ash or charcoal on the forehead of a baby before leaving home and going outside. Similarly, there was a significant association ($\chi^2= 132.082$, $df = 25$ and $p = .000$, which is less than .05) found between the respondents of different religious groups in their perception on putting *tikā* of turmeric or ash or charcoal on the forehead of a baby before leaving home and going outside.

7.5.4 Perception on Tie-round-thread into Bar, Pipal or Big trees on the Way in Carrying Baby

In villages, the mother who carries her baby with her in the way, she also carries a sacred thread (*Kānchodhāgo*) and *achhetā*. When she meets a *chaupari* or trees of *Bar* or *Pipal* or *Swāmi* or other kinds of big trees, then she ties several rounds of thread and sprinkle *achhetā* on the base of the tree and walk ahead. Generally, people believe that evil-spirit lives in big trees which can cause illness for a baby. Doing this, the evil-spirit cannot pierce (*chhalnu*) to the baby and become healthy. The opinion of respondents about this custom is discussed here.

The age and sex-wise opinion and association about tie several rounds of sacred thread and sprinkling *achhetā* on the base of *Bar*, *Pipal* or big trees on the ways when carrying a baby together are presented in table 7.57:

Table 7.57: Perception about Tie Thread around the Bar, Pipal or Big Trees by Age and Sex

Age		Responses						Total	Pearson Chi-Square	
		Prevent from evil-spirit	Wishing not become illness	Being traditional custom	superstition	Prevent from Mos, somokke (Infantile diarrhoea)	Don't Know			
Under 25	Count	9	4	17	3	3	4	40	Asymp. Sig. (2-sided) .000	
	%	22.5	10.0	42.5	7.5	7.5	10.0	100		
26 - 35	Count	38	29	43	7	8	4	129		
	%	29.5	22.5	33.3	5.4	6.2	3.1	100		
36 - 45	Count	50	42	35	6	8	4	145		
	%	34.5	29.0	24.1	4.1	5.5	2.8	100		
46 - 55	Count	38	47	29	3	12	1	130		
	%	29.2	36.2	22.3	2.3	9.2	0.8	100		
56 - 65	Count	35	41	23	3	9	0	111		
	%	31.5	36.9	20.7	2.7	8.1	0.0	100		
66 & above	Count	23	42	9	1	5	1	81		
	%	28.4	51.9	11.1	1.2	6.2	1.2	100		
Total	Count	193	205	156	23	45	14	636		
	%	30.3	32.2	24.5	3.6	7.1	2.2	100		
Sex										

Female	Count	96	109	78	4	25	6	318	Asymp. Sig. (2- sided) .043
	%	30.2	34.3	24.5	1.3	7.9	1.9	100	
Male	Count	97	96	78	19	20	8	318	
	%	30.5	30.2	24.5	6.0	6.3	2.5	100	
Total	Count	193	205	156	23	45	14	636	
	%	30.3	32.2	24.5	3.6	7.1	2.2	100	

Source: Field survey, 2015.

The table 7.57 shows that the respondents of 30.3% had the opinion in preventing from the evil-spirit, 32.2% respondents had an opinion on wishing not becoming ill, 24.2% respondents had an opinion on being traditional custom, 7.1% respondents had an opinion from prevention of local illness *Mos, somokke* (a kind of infantile diarrhoea) and only 3.6% respondents had an opinion of superstition about the tie several rounds of sacred thread and sprinkle *achhetā* on the base of *Bar, Pipal* or big trees in the ways when carrying baby together. Age-wise, younger age groups were found higher percentage in opinion on being traditional custom and older age groups were found higher percentage in opinion on wishing not to become ill. Sex-wise, females were in higher percentage in the opinion on wishing not become illness about the culture of tie several rounds of sacred thread and sprinkle *achhetā* in the base of *Bar, Pipal* or big trees in the ways when carrying baby together.

The Chi-Square (χ^2) test shows that there was a significant association ($\chi^2 = 62.139$, $df = 25$ and $p = .000$, which is less than .05) found between the respondents of different age-wise groups in their opinion ritual of tie several rounds of sacred thread and sprinkle *achhetā* in the base of *Bar, Pipal* or big trees in the ways when carrying baby together. Similarly, there was a significant association ($\chi^2 = 11.453$, $df = 5$ and $p = .043$, which is less than .05) found between the respondents of different sex-wise groups in their opinion ritual of tie several rounds of sacred thread and sprinkle *achhetā* in the base of *Bar, Pipal* or big trees in the ways when carrying baby together.

The education and religion-wise opinion and association about the tie several rounds of sacred thread and sprinkle *achhetā* in the base of *Bar, Pipal* or big trees in the ways when carrying baby together is presented in table 7.58:

Table 7.58: Perception about Tie Thread around the Bar, Pipal or Big Trees by Education and Religion

Education Level		Response						Total	Pearson Chi-Square	
		Prevent from evil-spirit	Wishing not become illness	Being traditional custom	superstition	Prevent from Mos, sommokke (Infantile diarrhoea)	Don't Know			
Illiterate	Count	29	41	14	0	3	2	89	Asymp. Sig. (2-sided) .000	
	%	32.6	46.1	15.7	0.0	3.4	2.2	100		
Literate/ Primary	Count	81	98	65	6	23	2	275		
	%	29.5	35.6	23.6	2.2	8.4	0.7	100		
Lower Secondary	Count	30	21	32	5	11	2	101		
	%	29.7	20.8	31.7	5.0	10.9	2.0	100		
Secondary	Count	36	36	27	9	3	4	115		
	%	31.3	31.3	23.5	7.8	2.6	3.5	100		
Certificate Level/+2	Count	12	4	15	3	4	2	40		
	%	30.0	10.0	37.5	7.5	10.0	5.0	100		
Bachelor & above	Count	5	5	3	0	1	2	16		
	%	31.3	31.3	18.8	0.0	6.3	12.5	100		
Total	Count	193	205	156	23	45	14	636		
	%	30.3	32.2	24.5	3.6	7.1	2.2	100		
Religion										
Traditional or Animist	Count	37	43	42	5	15	4	146		Asymp. Sig. (2-sided) .000
	%	25.3	29.5	28.8	3.4	10.3	2.7	100		
Buddhist	Count	37	22	20	2	4	0	85		
	%	43.5	25.9	23.5	2.4	4.7	0.0	100		
Hindu	Count	109	121	85	12	21	8	356		
	%	30.6	34.0	23.9	3.4	5.9	2.2	100		
Christian	Count	2	0	1	3	0	1	7		
	%	28.6	0.0	14.3	42.9	0.0	14.3	100		
Atheism/ Nastik	Count	1	0	1	0	0	0	2		
	%	50.0	0.0	50.0	0.0	0.0	0.0	100		
Don't Know	Count	7	19	7	1	5	1	40		
	%	17.5	47.5	17.5	2.5	12.5	2.5	100		
Total	Count	193	205	156	23	45	14	636		
	%	30.3	32.2	24.5	3.6	7.1	2.2	100		

Source: Field survey, 2015.

The table 7.58 shows that the Chi-Square (χ^2) test shows that there was a significant association ($\chi^2 = 58.193$, $df = 25$ and $p = .000$, which is less than .05) found between the respondents of different *education level*-wise groups in their opinion ritual of tie several rounds of sacred thread and sprinkle *achhetā* in the base of *Bar*, *Pipal* or big trees. Similarly, there was a significant association ($\chi^2 = 61.885$, $df = 25$ and $p = .000$, which is less than .05) found between the respondents of different *religion*-wise groups in their opinion ritual of tie several rounds of sacred thread and sprinkle *achhetā* in the base of *Bar*, *Pipal* or big trees.

7.6 Perception towards Rituals

In Magar culture and society, some cultures seem directly linked with the health, illness and well beings such as burning and making smoke of poisonous or allergic plants in a naming ceremony, practices of cross-cousin marriages, sanitation in death ritual and so on. Here, to understand the perception and knowledge of health and well-being in their ritual practices, which can be observed commonly in the Magar villages are raised in the questionnaire to analyse quantitatively.

7.6.1 Perception on Using Allergic, Poisonous and Thorny Plants in Naming Ceremony

The Magars collect local plants such as *Bhalāyo* (sumac), *Ban-kurilo* (asparegus), *Siru* (cagon-grass/hay grass) and other plants which are allergic, poisonous and thorny poisonous. Then they burn and make smoke in the house on the naming ceremony (*nwāran*). The smoke is exposed to the child because these allergic, poisonous and thorny poisonous plants can provide immunization to the new born babies. And helps to adapt and adjust to the local environment¹⁰. The local peoples are taken as those poisonous plant cause illness when exposing or coming in contact and need to avoid these plants for prevention of illness. The views of respondents in this matter are discussed here.

The age and sex-wise view about the burning and making smoke of local allergic, poisonous and thorny poisonous plants like *Bhalāyo* (sumac), *Ban kurilo* (asparegus), *Siru* (cagon-grass/hay grass) in the house on naming ceremony is presented in table 7.59:

Table 7.59: Opinion on exposing to Baby in Fume of Local Plants in Naming Ceremony which could be Allergic, Thorny and Poisonous by Age and Sex

Age		Responses							Total	Pearson Chi-Square	
		(1) To prevent from the illness	(2) To prevent from the those poisonous plants	Being traditional custom	Superstition	Code 01 & 02 both	We don't this custom	Don't allow by my religion			Don't Know
Under 25	Count	8	11	13	2	0	0	1	5	40	Asymp. Sig. (2-sided) .000
	%	20.0	27.5	32.5	5.0	0.0	0.0	2.5	12.5	100	
26 - 35	Count	18	44	49	8	1	1	0	8	129	
	%	14.0	34.1	38.0	6.2	0.8	0.8	0.0	6.2	100	
36 - 45	Count	24	69	37	8	1	0	0	6	145	
	%	16.6	47.6	25.5	5.5	0.7	0.0	0.0	4.1	100	
46 - 55	Count	17	66	37	2	3	0	0	5	130	
	%	13.1	50.8	28.5	1.5	2.3	0.0	0.0	3.8	100	
56 - 65	Count	19	58	24	0	4	1	2	3	111	
	%	17.1	52.3	21.6	0.0	3.6	0.9	1.8	2.7	100	
66	Count	7	55	15	0	2	0	0	2	81	

¹⁰Based on conversation with Pro.Dr.KesharjangBaralMagar on 18/11/2014 at Pokhara.

&above	%	8.6	67.9	18.5	0.0	2.5	0.0	0.0	2.5	100	
Total	Count	93	303	175	20	11	2	3	29	636	
	%	14.6	47.6	27.5	3.1	1.7	0.3	0.5	4.6	100	
Sex											
Female	Count	50	150	95	1	3	0	2	17	318	Asym p. Sig. (2- sided) .001
	%	15.7	47.2	29.9	0.3	0.9	0.0	0.6	5.3	100	
Male	Count	43	153	80	19	8	2	1	12	318	
	%	13.5	48.1	25.2	6.0	2.5	0.6	0.3	3.8	100	
Total	Count	93	303	175	20	11	2	3	29	636	
	%	14.6	47.6	27.5	3.1	1.7	0.3	0.5	4.6	100	

Source: Field Survey, 2015.

The table 7.59 shows that the majority Magar respondents gave opinion on prevention of the illness (14.6%) and from poisonous plants (47.6%) that could cause illness. Respondents of 27.5% were given opinion of traditional custom, 3.1% respondents were stated as superstition on using allergic, poisonous and thorny plants in a naming ceremony. The respondents of older age groups were found higher percentage in the opinion of prevention from illness and poisonous plants which cause illness. Sex wise, females were slightly higher percentage in the opinion of prevention from illness.

The Chi-Square (χ^2) test shows that there was a significant association ($\chi^2= 69.899$, $df = 35$ and $p = .000$, which is less than .05) found between the respondents of different *age-wise* groups in their perception on using local plants which could be allergic, poisonous and thorny poisonous, in naming ceremony. Similarly, there was a significant association ($\chi^2= 23.510$, $df = 7$ and $p = .001$, which is less than .05) found between the respondents of different *sex-wise* groups in their perception on using local plants which could be allergic, poisonous and thorny poisonous, to complete the ritual of naming ceremony.

The education and religion-wise view about the burning and making smoke of local allergic, poisonous and thorny poisonous plants like *Bhalāyo* (sumac), *Ban Kurilo* (asparagus), *Siru* (cogon-grass/hay grass) in the house on naming ceremony is presented in table 7.60:

Table 7.60: Opinion on exposing to Baby in Fume of Local Plants in Naming Ceremony which could be Allergic, Thorny and Poisonous by Education and Religion

Education Level	Response									Total	Pears on Chi-Square
	(1) To prevent from illness	(2) To prevent from those poisonous plants	Being traditional custom	Superstition	Code 01& 02 both	We don't this custom	Don't allow by my religion	Don't Know			
Illiterate	Count	11	52	23	0	0	0	0	3	89	Asym p. Sig. (2- sided) .001
	%	12.4	58.4	25.8	0.0	0.0	0.0	0.0	3.4	100	
Literate/Primary	Count	37	147	68	1	9	1	2	10	275	
	%	13.5	53.5	24.7	0.4	3.3	0.4	0.7	3.6	100	

Lower Secondary	Count	19	37	31	7	1	0	0	6	101	sided) .003
	%	18.8	36.6	30.7	6.9	1.0	0.0	0.0	5.9	100	
Secondary	Count	17	44	37	9	1	0	1	6	115	
	%	14.8	38.3	32.2	7.8	0.9	0.0	0.9	5.2	100	
Certificate Level/+2	Count	4	16	12	3	0	1	0	4	40	
	%	10.0	40.0	30.0	7.5	0.0	2.5	0.0	10	100	
Bachelor & above	Count	5	7	4	0	0	0	0	0	16	
	%	31.3	43.8	25.0	0.0	0.0	0.0	0.0	0.0	100	
Total	Count	93	303	175	20	11	2	3	29	636	
	%	14.6	47.6	27.5	3.1	1.7	0.3	0.5	4.6	100	
Religion											
Traditional or Animist	Count	21	52	55	5	4	1	0	8	146	
	%	14.4	35.6	37.7	3.4	2.7	0.7	0.0	5.5	100	
Buddhist	Count	21	41	18	3	0	0	0	2	85	
	%	24.7	48.2	21.2	3.5	0.0	0.0	0.0	2.4	100	
Hindu	Count	49	189	86	11	6	1	0	14	356	Asym p. Sig. (2- sided) .000
	%	13.8	53.1	24.2	3.1	1.7	0.3	0.0	3.9	100	
Christian	Count	0	1	3	0	0	0	3	0	7	
	%	0.0	14.3	42.9	0.0	0.0	0.0	42.9	0	100	
Atheism/ Nastik	Count	0	1	1	0	0	0	0	0	2	
	%	0.0	50.0	50.0	0.0	0.0	0.0	0.0	0.0	100	
Don't Know	Count	2	19	12	1	1	0	0	5	40	
	%	5.0	47.5	30.0	2.5	2.5	0.0	0.0	12.5	100	
Total	Count	93	303	175	20	11	2	3	29	636	
	%	14.6	47.6	27.5	3.1	1.7	0.3	0.5	4.6	100	

Source: Field Survey, 2015.

The table No 7.60 shows that respondents of lower education level found higher percentage in opinion on to prevent from those poisonous plants and respondents of higher education level were found higher percentage in opinion on to prevent from the illness. Religion-wise, respondents of Hindu, Buddhist were higher percentage in opinion on to prevent from those poisonous plants and the respondents from the Christian (42.9%) gave their opinion that they had not allowed due to religion, which indicates the cultural conflict is going to increase among Magars due to adopting new religions.

The Chi-Square (χ^2) test shows that there was a significant association ($\chi^2= 62.904$, $df = 35$ and $p = .003$, which is less than .05) found between the respondents of different *education level*-wise groups in their perception on using local plants which could be allergic, poisonous and thorny poisonous, in the naming ceremony. Similarly, there was a significant association ($\chi^2= 308.580$, $df = 35$ and $p = .000$, which is less than .05) found between the respondents of different *religion*-wise groups in their perception on using local plants which could be allergic, poisonous and thorny poisonous, to complete the ritual of naming ceremony.

7.6.2 Perception towards Cross-cousin Marriage

In Magar culture and society cross-cousin marriage is prevailing as a customary system and they do marriage between the daughters of maternal uncle (*Sāli*) and the sons of sisters/*Bhenā* (*mama cheli-phupuchelā*). However, it is prohibited between the daughters of sister (*Bhānji*) and the brother's son (*Jethu*). Here the result of the respondents' opinion about cross-cousin marriage from the perspective of health is discussed.

The location and language-wise distribution of opinion and association about the cross-cousin marriage among the Magars are presented in table 7.61:

Table 7.61: Perception towards Cross-cousin Marriage among the Magars

VDC		Response				Total	Pearson Chi-Square
		Knowing health status of each other	To prevent communicable disease	Only keep kinship relationship	Don't Know		
Alamdevi	Count	20	16	41	10	87	Asymp. Sig. (2-sided) .000
	%	23.0	18.4	47.1	11.5	100	
Birgha	Count	26	9	29	0	64	
	%	40.6	14.1	45.3	0.0	100	
ChandiBhanjyna	Count	12	12	50	6	80	
	%	15.0	15.0	62.5	7.5	100	
Jagatradevi	Count	30	9	73	10	122	
	%	24.6	7.4	59.8	8.2	100	
Malungga	Count	9	1	10	7	27	
	%	33.3	3.7	37.0	25.9	100	
Nibuwakharaka	Count	14	0	32	11	57	
	%	24.6	0.0	56.1	19.3	100	
Pelakot	Count	12	10	26	6	54	
	%	22.2	18.5	48.1	11.1	100	
Pindikhola	Count	10	6	17	4	37	
	%	27.0	16.2	45.9	10.8	100	
ShreeKrishna Gandaki	Count	34	12	54	8	108	
	%	31.5	11.1	50.0	7.4	100	
Total	Count	167	75	332	62	636	
	%	26.3	11.8	52.2	9.7	100	
Language							
Magar	Count	161	68	320	56	605	Asymp. Sig. (2-sided) .045
	%	26.6	11.2	52.9	9.3	100	
Nepali	Count	6	7	12	6	31	
	%	19.4	22.6	38.7	19.4	100	
Total	Count	167	75	332	62	636	
	%	26.3	11.8	52.2	9.7	100	

Source: Field Survey, 2015.

The table 7.61 shows that the majority of respondents (52.2%) gave opinion on only keep kinship relationships, and regarding health perspectives, respondents of 26.3% gave their opinion on knowing health status of each other, 11.8% of respondents gave their opinion to prevent communicable diseases. In addition, 9.7% of respondents found unknown reasons for

the cross-cousin marriages among the Magars. Language-wise, 52.9% of respondents of Magar language speakers were in the opinion on only keep kinship relationships and having Nepali language mother tongue respondents (19.4%) were unknown. Location-wise, the respondents of Birgha VDC were found higher percentage in the opinion of health status knowledge each other before marriage.

The Chi-Square (χ^2) test shows that there was a significant association ($\chi^2= 55.039$, $df = 24$ and $p = .000$, which is less than .05) found between the respondents of different respondents of VDC wise groups in their perception on reason of cross-cousin marriage among the Magars. Similarly, there was a significant association ($\chi^2= 8.029$, $df = 3$ and $p = .045$, which is less than .05) found between the respondents of different *language*-wise groups in their perception on the reason of cross-cousin marriage among the Magars.

7.6.3 Knowledge on Probability of Hereditary Defects in Cross-cousin Marriage

The modern medical (bio-medicine) has indicated the probability of hereditary defects or defects or diseases (e.g., disability, mental retardation, sickle cell anaemia, etc) in the foetus and new born babies when having close kinship marriages or cross-cousin marriages. The result of the survey on knowledge of respondents in probability of hereditary defects on foetus or infants due to cross-cousin is discussed here.

The education and religion-wise knowledge towards probability of hereditary defects or diseases due to cross-cousin marriages among the Magars are presented in table 7.62:

Table 7.62: Knowledge on Probability of Hereditary Defects by Education and Religion

Education Level		Response			Total	Pearson Chi-Square
		Known	Heard only	Unknown		
Illiterate	Count	7	30	52	89	Asymp. Sig. (2-sided) .002
	% within Education	7.9	33.7	58.4	100	
Literate/ Primary	Count	22	118	135	275	
	% within Education	8.0	42.9	49.1	100	
Lower Secondary	Count	7	51	43	101	
	% within Education	6.9	50.5	42.6	100	
Secondary	Count	12	48	55	115	
	% within Education	10.4	41.7	47.8	100	
Certificate Level/+2	Count	11	7	22	40	
	% within Education	27.5	17.5	55.0	100	
Bachelor & above	Count	2	7	7	16	
	% within Education	12.5	43.8	43.8	100	
Total	Count	61	261	314	636	
	% within Education	9.6	41.0	49.4	100	
Religion						
Traditional or Animist	Count	8	76	62	146	Asymp. Sig. (2-sided) .002
	% within Religion	5.5	52.1	42.5	100	

Buddhist	Count	4	30	51	85	sided) .017
	% within Religion	4.7	35.3	60.0	100	
Hindu	Count	46	138	172	356	
	% within Religion	12.9	38.8	48.3	100	
Christian	Count	0	3	4	7	
	% within Religion	0.0	42.9	57.1	100	
Atheism /Nastik	Count	0	0	2	2	
	% within Religion	0.0	0.0	100.0	100	
Don't Know	Count	3	14	23	40	
	% within Religion	7.5	35.0	57.5	100.0	
Total	Count	61	261	314	636	
	% within Religion	9.6	41.0	49.4	100	

Source: Field Survey, 2015.

The table 7.62 shows that the respondents of 49.4% found unknown, 9.6% respondents found known and 41% of respondents claimed heard only about the probability of hereditary defects or diseases in foetus or infant doing cross-cousin marriages, which is prevailed in Magar society. Education-wise, the respondents of higher education level were higher percentage in known and heard only category, and religion-wise, the respondents from Hindu were higher percentage in known and heard only category about the probability of hereditary defects due to cross-cousin marriages.

The Chi-Square (χ^2) test shows that there was a significant association ($\chi^2 = 27.236$, $df = 10$ and $p = .002$, which is less than .05) found between the respondents of different *education level*-wise groups in their knowledge on probability of hereditary defects or diseases in foetus or infants due to cross-cousin marriages among the Magars. Similarly, there was a significant association ($\chi^2 = 21.557$, $df = 10$ and $p = .017$, which is less than .05) found between the respondents of different *religion*-wise groups in their knowledge on the probability of hereditary defects or diseases in foetus or infants due to cross-cousin marriages among the Magars.

7.6.4 Perception on Smear (cleaning) House, Inside to Outside Direction in Death Ritual

In Magar villages when they carry the deceased body out of the house for final cremation, then they smear (clean) from inside to outside direction. The result of beliefs of the respondents about this smearing house inside to outside direction on the death ceremony is discussed here.

VDC-wise, the distribution of the perception about the reason of smearing (cleaning) process in the house from inside to outside direction is carried out deceased for cremation is presented in table 7.63:

Table 7.63: Perception on Smearing (cleaning) process at House from inside to outside direction in Death Rituals

VDC		Response							Total	Pears on Chi-Square
		To throw out disease / illness	To clean house/ Ritually pure	To push out soul of deceased	Being traditional custom	To make ritually pure for soul to stay in the heaven	Superstition	Don't Know		
Alamdevi	Count	4	11	30	9	8	3	22	87	Asym p. Sig. (2-sided) .000
	%	4.6	12.6	34.5	10.3	9.2	3.4	25.3	100	
Birgha	Count	2	4	36	1	0	0	21	64	
	%	3.1	6.3	56.3	1.6	0.0	0.0	32.8	100	
ChandiBhanjyna	Count	13	18	23	4	2	0	20	80	
	%	16.3	22.5	28.8	5.0	2.5	0.0	25.0	100	
Jagatradevi	Count	8	49	45	11	0	0	9	122	
	%	6.6	40.2	36.9	9.0	0.0	0.0	7.4	100	
Malungga	Count	4	12	4	3	0	0	4	27	
	%	14.8	44.4	14.8	11.1	0.0	0.0	14.8	100	
Nibuwakharka	Count	8	11	10	19	0	0	9	57	
	%	14.0	19.3	17.5	33.3	0.0	0.0	15.8	100	
Pelakot	Count	8	3	21	12	0	0	10	54	
	%	14.8	5.6	38.9	22.2	0.0	0.0	18.5	100	
Pindikholola	Count	2	8	13	7	0	0	7	37	
	%	5.4	21.6	35.1	18.9	0.0	0.0	18.9	100	
Shree Krishna Gandaki	Count	2	1	45	34	2	0	24	108	
	%	1.9	0.9	41.7	31.5	1.9	0.0	22.2	100	
Total	Count	51	117	227	100	12	3	126	636	
	%	8.0	18.4	35.7	15.7	1.9	0.5	19.8	100	

Source: Field Survey, 2015.

The table 7.63 shows that the respondents of Chandibhanjyang VDC were in higher percentage in the opinion of throwing out illness and the respondents from the Malungga VDC were higher percentage in opinion on to clean house and make ritually pure in reason of smearing (cleaning) process in the house from inside to outside direction when carried out deceased for cremation from home in death rituals.

The Chi-Square (χ^2) test shows that there was a significant association ($\chi^2 = 231.843$, $df = 48$ and $p = .000$, which is less than .05) found between the respondents of different respondent of VDC-wise groups in their perception on reason of smearing (cleaning) processing the house from inside to outside direction when carried out deceased for cremation from home in death rituals.

7.7 Mental Illness

Mental health and care of mental illness is an important portion of health care and healings. Emile Durkheim (1951) described that in individual the mental illness and suicide arises from the social causes and enforced through the society. However, every society has constructed its own perception about mental health. In bio-medicine, mental illness is categorized from mild to severe and mental health affects psychological health, behavioural health as well as physical health. Psychosis is severe illness and depression, anxiety, hysteria could mild to severe. Other illnesses such as mental retardation, poor development of the brain with low intelligence, alcoholism, and psychosexual disorders are also mental illnesses (Kafle and Pinniger, 1999, p.99; Wright and Nepal, 1998, pp.292-301). However, generally in the community, mental illness is known for depression, anxiety, psychosis and related disorders.

7.7.1 Beliefs about Causation of Mental Illness

The results of field survey in perception on the causation of mental illness among the Magars are discussed here. The age and education-wise perception and association towards causation of mental illness are presented in table 7.64:

Table 7.64: Perception on Causation of Mental Illness by Age and Education

Age		Response						Total	Pearson Chi-Square
		Being anger Godlings/ God spirit	Envy by the Ghost, Masan, Nidini, etc. Evil spirit	Deficiency of security and love from the family	Insecurity from the relative, society	Taking excessive thinking / tension	Don't Know		
Under 25	Count	2	2	9	8	17	2	40	Asymp . Sig. (2-sided) .000
	%	5.0	5.0	22.5	20.0	42.5	5.0	100	
26 - 35	Count	16	8	21	12	62	10	129	
	%	12.4	6.2	16.3	9.3	48.1	7.8	100	
36 - 45	Count	14	13	23	12	70	13	145	
	%	9.7	9.0	15.9	8.3	48.3	9.0	100	
46 - 55	Count	20	21	12	10	52	15	130	
	%	15.4	16.2	9.2	7.7	40.0	11.5	100	
56 - 65	Count	28	16	7	3	40	17	111	
	%	25.2	14.4	6.3	2.7	36.0	15.3	100	
66 & above	Count	28	10	6	3	25	9	81	
	%	34.6	12.3	7.4	3.7	30.9	11.1	100	
Total	Count	108	70	78	48	266	66	636	
	%	17.0	11.0	12.3	7.5	41.8	10.4	100	
Education Level									
Illiterate	Count	24	11	2	3	31	18	89	Asymp . Sig. (2-sided) .000
	%	27.0	12.4	2.2	3.4	34.8	20.2	100	
Literate/ Primary	Count	66	39	31	17	89	33	275	
	%	24.0	14.2	11.3	6.2	32.4	12.0	100	
Lower	Count	9	13	10	7	55	7	101	

Secondary	%	8.9	12.9	9.9	6.9	54.5	6.9	100
Secondary	Count	6	5	23	7	67	7	115
	%	5.2	4.3	20.0	6.1	58.3	6.1	100
Certificate Level/+2	Count	2	2	8	11	17	0	40
	%	5.0	5.0	20.0	27.5	42.5	0.0	100
Bachelor & above	Count	1	0	4	3	7	1	16
	%	6.3	0.0	25.0	18.8	43.8	6.3	100
Total	Count	108	70	78	48	266	66	636
	%	17.0	11.0	12.3	7.5	41.8	10.4	100

Source: Field Survey, 2015.

The table 7.58 shows, that respondents of 17.0% expressed their opinion on being anger godlings or god-spirit, 11% of respondents expressed their opinion on Envy by the Ghost, *Masan*, *Nidini*, etc. evil spirit. The 12.3% respondents were told their opinion on deficiency of security and love from the family and 7.5 respondents had an opinion on Insecurity from the relative, society. In addition, 41.8% of respondents gave their opinion on taking excessive thinking/ tension and 10.4% of respondents were unknown about the causes of the mental illness.

The respondents of younger age groups were higher percentage in the opinion of taking excessive thinking/ Anxiety and old age group respondents (34.6%) were opinion on being anger godlings or god-spirit. Education-wise respondents having secondary level education (58.3%) were opinion on taking excessive thinking/ tension.

The Chi-Square (χ^2) test shows that there was a significant association ($\chi^2 = 75.259$, $df = 25$ and $p = .000$, which is less than .05) found between the respondents of different *age*-wise groups in their perception on causation of mental illness among the Magars. Similarly, there was a significant association ($\chi^2 = 120.970$, $df = 25$ and $p = .000$, which is less than .05) found between the respondents of different *education level*-wise groups in their perception on causation of mental illness among the Magars

The religion, marital status and language-wise perception and association towards causation of mental illness is presented in table 7.65:

Table 7.65: Perception on Causation of Mental Illness by Religion, Marital Status and Language

Religion		Response						Total	Pearson Chi-Square	
		Being anger Godlings/God spirit	Envy by the Ghost, Masan, Nidini, etc. Evil spirit	Deficiency of security and love from the family	Insecurity from the relative, society	Taking excessive thinking/tension	Don't Know			
Traditional or Animist	Count	34	24	15	9	54	10	146	Asymp. Sig. (2-sided) .000	
	%	23.3	16.4	10.3	6.2	37.0	6.8	100		
Buddhist	Count	7	8	6	8	53	3	85		
	%	8.2	9.4	7.1	9.4	62.4	3.5	100		
Hindu	Count	50	36	53	30	139	48	356		
	%	14.0	10.1	14.9	8.4	39.0	13.5	100		
Christian	Count	1	0	1	0	4	1	7		
	%	14.3	0.0	14.3	0.0	57.1	14.3	100		
Atheism/ Nastik	Count	0	0	0	0	2	0	2		
	%	0.0	0.0	0.0	0.0	100.0	0.0	100		
Don't Know	Count	16	2	3	1	14	4	40		
	%	40.0	5.0	7.5	2.5	35.0	10.0	100		
Total	Count	108	70	78	48	266	66	636		
	%	17.0	11.0	12.3	7.5	41.8	10.4	100		
Marital Status										
Married	Count	85	57	68	38	227	47	522		Asymp. Sig. (2-sided) .000
	%	16.3	10.9	13.0	7.3	43.5	9.0	100		
Unmarried	Count	0	0	4	5	6	0	15		
	%	0.0	0.0	26.7	33.3	40.0	0.0	100		
Single (Widow/ Widower)	Count	23	12	6	5	33	19	98		
	%	23.5	12.2	6.1	5.1	33.7	19.4	100		
Divorced	Count	0	1	0	0	0	0	1		
	%	0.0	100.0	0.0	0.0	0.0	0.0	100		
Total	Count	108	70	78	48	266	66	636		
	%	17.0	11.0	12.3	7.5	41.8	10.4	100		
Language										
Magar	Count	106	70	72	47	252	58	605	Asymp. Sig. (2-sided) .009	
	%	17.5	11.6	11.9	7.8	41.7	9.6	100		
Nepali	Count	2	0	6	1	14	8	31		
	%	6.5	0.0	19.4	3.2	45.2	25.8	100		
Total	Count	108	70	78	48	266	66	636		
	%	17.0	11.0	12.3	7.5	41.8	10.4	100		

Source: Field Survey, 2015.

The table 7.65 shows that religion-wise respondents from Buddhist religion were relatively higher percentage in opinion on taking excessive thinking or tension and respondent from not knowing their own religion and traditional/animist groups were higher percentage in being anger godlings or god-spirit in causation of illness. Marital status-wise, married respondents were higher percentage in opinion on taking excessive tension or thinking. Language-wise,

the respondents having Nepali language as a mother tongue were higher percentage in on taking excessive thinking or tension. An individual could take excessive thinking or tension due to several social causes and consequences.

The Chi-Square (χ^2) test shows that there was a significant association ($\chi^2= 58.803$, $df = 25$ and $p = .000$, which is less than .05) found between the respondents of different *religion*-wise groups in their perception on causation of mental illness among the Magars. Similarly, there was a significant association ($\chi^2=49.929$, $df = 15$ and $p = .000$, which is less than .05) found between the respondents of different *marital status* wise groups in their perception on causation of mental illness among the Magars and that there was a significant association ($\chi^2= 15.419$, $df = 5$ and $p = .009$, which is less than .05) found between the respondents of different language groups in their perception on causation of mental illness among the Magars.

The religion, marital status and language-wise perception and association towards causation of mental illness are presented in table 7.66:

Table 7.66: Perception on Causation of Mental Illness by Occupation

Occupation		Response						Total	Pearson Chi-Square
		Being anger Godlings/God spirit	Envy by the Ghost, Masan, Nidini, etc. Evil spirit	Deficiency of security and love from the family	Insecurity from the relative, society	Taking excessive thinking/tension	Don't Know		
Agriculture	Count	63	34	38	17	142	44	338	Asymp . Sig. (2-sided) .000
	%	18.6	10.1	11.2	5.0	42.0	13	100	
Job/ service in Nepal	Count	1	0	12	7	6	2	28	
	%	3.6	0.0	42.9	25.0	21.4	7.1	100	
Construction/ Maintenance	Count	4	3	2	6	5	0	20	
	%	20.0	15.0	10.0	30.0	25.0	0.0	100	
Business	Count	4	2	5	2	18	2	33	
	%	12.1	6.1	15.2	6.1	54.5	6.1	100	
Foreign Employment	Count	3	5	4	2	17	1	32	
	%	9.4	15.6	12.5	6.3	53.1	3.1	100	
Job in India	Count	2	3	3	4	11	0	23	
	%	8.7	13.0	13.0	17.4	47.8	0.0	100	
House wife	Count	6	7	5	3	23	1	45	
	%	13.3	15.6	11.1	6.7	51.1	2.2	100	
Ex-Army/Pensioner/Army in India or UK	Count	25	15	9	3	39	16	107	
	%	23.4	14.0	8.4	2.8	36.4	15	100	
Others	Count	0	1	0	4	5	0	10	
	%	0.0	10.0	0.0	40.0	50.0	0.0	100	
Total	Count	108	70	78	48	266	66	636	
	%	17.0	11.0	12.3	7.5	41.8	10.4	100	

Source: Field Survey, 2015.

The table 7.66 shows, the respondents having occupation business, housewife were higher percentage in opinion on taking excessive thinking or tension and higher percentage of having an occupation as ex-army/ pensioner or army in India or UK in the opinion of being anger godlings or god-spirit.

The Chi-Square (χ^2) test shows that there was a significant association ($\chi^2= 113.630$, $df = 40$ and $p = .000$, which is less than .05) found between the respondents of different *occupation* wise groups in their perception on causation of mental illness among the Magars.

7.7.2 Likert Scale Distribution Perception towards Mental Illness

Social factors such as socio-cultural, socio-economic, social structure and function, or whole society are responsible to create Mental illness in individuals. Every society has their-own views and perceptions toward mental illness, curing mental illness, social & family sympathy. The Likert Scale statements are given as follows:

Table 7.67: Likert Scale Statements about Perception towards Mental Illness

Statements	Agree		Uncertain		Disagree		Total	
	N	%	N	%	N	%	N	%
<i>D 25. People suffering from psychosis or mental diseases are curable.</i>	441	69.4	189	29.7	6	0.9	636	100
<i>D.26 Family, relative and social support, assurance and love are essential to people who are suffering from mental illness.</i>	552	86.8	69	10.8	15	2.4	636	100

Source: Field Survey, 2015

The above three-degree response Likert Scale statements about hope of cure of Mental illness and perception of family or social support for curing mental illness are analysed and result discussed as follows:

Here, according to Kothari and Garg (2015, pp 78-80), if the instruments consists 2 statements (Likert Scale questions) and three degrees, the following score value would be revealing:

$2 \times 3 = 6$ Most of unfavourable attitudes

$2 \times 2 = 4$ neutral attitude

$2 \times 1 = 1$ Most of favourable responses

Hence, here score for any individual would fall between 2 and 6. The score above 4; it shows that having negative perception and the score below 4 shows that having a positive perception towards hope of cure of mental illness, social and family support to the ill person. Exactly 4 is suggestive of neutral or undecided. The Likert Scale score distribution of perception on knowledge of curing illness and need of support for a mentally ill person among the Magars is presented in table 7.68:

Table 7.68: Distribution of Likert Scale Score on knowledge on Curing and Need of Support for Mentally-ill Person

Score	Knowledge on Curing and Need of Support for Mental-ill Person			
	Frequency	Percent	Valid Percent	Cumulative Percent
2.00	433	68.1	68.1	68.1
3.00	119	18.7	18.7	86.8
4.00	76	11.9	11.9	98.7
5.00	3	0.5	0.5	99.2
6.00	5	0.8	0.8	100.0
Total	636	100.0	100.0	

Source: Field Survey, 2015.

The table 7.68 shows that the respondents of 68.1% were found having a strong positive response, cumulatively 86.6% of respondents were found having a positive response to mental illness can be cured and need support for a mentally ill person. Further, 11.9% of respondents were neutral or undecided about the Likert statements. Only 1.3% of respondents had a negative response to mental illness can be cured and need support for a mentally ill person. However, in the Magar villages awareness about the healing of mental illness, support from the family, kinship and society for an ill person is found among the Magars. But, there is lack of in-depth knowledge and awareness towards mental illness and caring, health facilities. And there is also lack of having well-equipped health care services.

7.8 Knowledge of Food and Nutrition

7.8.1 Knowledge about Causation of Illness due to Imbalanced of Diet

Balanced diet is the way of a healthy life. The habits of over-eating, under-eating and timely not eating, using stale and musty food can cause to illness. Hygienic and balanced nutrition in food can help for a healthy life. Here, the result of opinions from the field survey in causation of illness due to taking unbalance food in daily life is presented in table 7.69:

Table 7.69: Knowledge about Causation of Illness due to Imbalanced of Diet in Daily Life

Education Level		Responses			Total	Pearson Chi-Square
		Yes	No	Don't Know		
Illiterate	Count	54	9	26	89	Asymp. Sig. (2-sided) .007
	% within Education	60.7	10.1	29.2	100	
Literate/Primary	Count	208	15	52	275	
	% within Education	75.6	5.5	18.9	100	
Lower Secondary	Count	74	5	22	101	
	% within Education	73.3	5.0	21.8	100	
Secondary	Count	98	3	14	115	
	% within Education	85.2	2.6	12.2	100	
Certificate Level/+2	Count	33	2	5	40	
	% within Education	82.5	5.0	12.5	100	
Bachelor & above	Count	16	0	0	16	
	% within Education	100.0	0.0	0.0%	100	
Total	Count	483	34	119	636	
	% within Education	75.9	5.3	18.7	100	

Source: Field Survey, 2015.

The table 7.69 shows that the majority of respondents (75.9%) had knowledge about the causation of illness due to unbalance food in daily life and 18.7% of respondents were unknown about the causation of illness due to unbalance food in daily life. But 5.3% of respondents were not agreed with the causation of illness due to imbalanced food in daily life. Education-wise, the respondents of higher education level had more positive responses about the causation of illness due to imbalanced food in daily life.

The Chi-Square (χ^2) test shows that there was a significant association ($\chi^2 = 24.080$, $df = 10$ and $p = .007$, which is less than .05) found between the respondents of different *education level*-wise groups in their knowledge on causation of illness due to unbalance food in daily life.

7.8.2 Knowledge about Nutritional Values in Taking Junk Foods for Daily Life

Junk foods are easily available in the Magar villages and inserted into the culture of the village. But proper knowledge about the nutrition of junk food and daily required nutrition values for child and individual is questionable and which can lead to malnutrition and illness.

Therefore, the results of field survey about proper knowledge in food and nutrition are discussed here.

The age, sex and education-wise distribution of the knowledge and association towards junk food and nutrition is presented in table No 7.70:

Table 7.70: Distribution of Knowledge about Nutrition Value by Sex, Age and Education

Sex		Responses			Total	Pearson Chi-Square
		Known	Heard only	Unknown		
Female	Count	169	105	44	318	Asymp. Sig. (2-sided) .026
	% within Sex	53.1	33.0	13.8	100	
Male	Count	197	95	26	318	
	% within Sex	61.9	29.9	8.2	100	
Total	Count	366	200	70	636	
	% within Sex	57.5	31.4	11.0	100	
Age						
Under 25	Count	30	9	1	40	Asymp. Sig. (2-sided) .001
	% within Age	75.0	22.5	2.5	100	
26 - 35	Count	84	32	13	129	
	% within Age	65.1	24.8	10.1	100	
36 - 45	Count	96	39	10	145	
	% within Age	66.2	26.9	6.9	100	
46 - 55	Count	72	41	17	130	
	% within Age	55.4	31.5	13.1	100	
56 - 65	Count	49	47	15	111	
	% within Age	44.1	42.3	13.5	100	
66 & above	Count	35	32	14	81	
	% within Age	43.2	39.5	17.3	100	
Total	Count	366	200	70	636	
	% within Age	57.5	31.4	11.0	100	
Education Level						
Illiterate	Count	22	40	27	89	Asymp. Sig. (2-sided) .000
	% within Education	24.7	44.9	30.3	100	
Literate/Primary	Count	157	90	28	275	
	% within Education	57.1	32.7	10.2	100	
Lower Secondary	Count	64	33	4	101	
	% within Education	63.4	32.7	4.0	100	
Secondary	Count	76	31	8	115	
	% within Education	66.1	27.0	7.0	100	
Certificate Level/+2	Count	34	4	2	40	
	% within Education	85.0	10.0	5.0	100	
Bachelor & above	Count	13	2	1	16	
	% within Education	81.3	12.5	6.3	100	
Total	Count	366	200	70	636	
	% within Education	57.5	31.4	11.0	100	

Source: Field Survey, 2015.

The table 7.70 shows that the majority of respondents (57.5%) told as they had knowledge, 31.4% respondents had heard only and 11% respondents were unknown about the sufficient or deficient nutrition values in junk foods for their daily needs calories to child and individuals.

Sex-wise, male respondents than females, age-wise, younger age groups than older age groups, education-wise, higher education level than lower education level respondents were higher percentage in having knowledge and awareness on sufficient or deficient nutritious values in junk food for their children and themselves.

The Chi-Square (χ^2) test shows that there was a significant association ($\chi^2= 7.271$, $df = 2$ and $p = .026$, which is less than .05) found between the respondents of different *sex*-wise groups in their knowledge and awareness on sufficient or deficient nutritious values in junk food for their children and themselves. Similarly, there was a significant association ($\chi^2= 30.397$, $df = 10$ and $p = .001$, which is less than .05) found between the respondents of different *age*-wise groups in their knowledge and awareness on sufficient or deficient nutritious values in junk food for their children and themselves. And, there was a significant association ($\chi^2= 77.587$, $df = 10$ and $p = .000$, which is less than .05) found between the respondents of different *education level*-wise groups in their knowledge and awareness on sufficient or deficient nutritious values in junk food for their children and themselves.

The occupation, religion and marital status-wise distribution of the knowledge and association towards junk food and nutrition is presented in table 7.71.

Table 7.71: Distribution of Knowledge about Nutrition Value by Occupation, Religion and Marital Status

Occupation		Response			Total	Pearson Chi-Square
		Know	Heard only	Don't Know		
Agriculture	Count	174	113	51	338	Asymp. Sig. (2-sided) .017
	% within Occupation	51.5	33.4	15.1	100	
Job/ service in Nepal	Count	22	4	2	28	
	% within Occupation	78.6	14.3	7.1	100	
Construction/ Maintenance works	Count	14	5	1	20	
	% within Occupation	70.0	25.0	5.0	100	
Business	Count	23	10	0	33	
	% within Occupation	69.7	30.3	0.0	100	
Foreign Employment	Count	18	13	1	32	
	% within Occupation	56.3	40.6	3.1	100	
Job in India	Count	16	6	1	23	
	% within Occupation	69.6	26.1	4.3	100	
House wife	Count	30	13	2	45	
	% within Occupation	66.7	28.9	4.4	100	
Ex-Army/Pensioner/Army in India or UK	Count	60	35	12	107	
	% within Occupation	56.1	32.7	11.2	100	
Others	Count	9	1	0	10	
	% within Occupation	90.0	10.0	0.0	100	
Total	Count	366	200	70	636	
	% within Occupation	57.5	31.4	11.0	100	

Religion							
Traditional or Animist	Count	79	52	15	146	Asymp. Sig. (2-sided) .032	
	% within Religion	54.1	35.6	10.3	100		
Buddhist	Count	55	29	1	85		
	% within Religion	64.7	34.1	1.2	100		
Hindu	Count	201	103	52	356		
	% within Religion	56.5	28.9	14.6	100		
Christian	Count	3	4	0	7		
	% within Religion	42.9	57.1	0.0	100		
Atheism/ Nastik	Count	1	1	0	2		
	% within Religion	50.0	50.0	0.0	100		
Don't Know	Count	27	11	2	40		
	% within Religion	67.5	27.5	5.0	100		
Total	Count	366	200	70	636		
	% within Religion	57.5	31.4	11.0	100		
Marital Status							
Married	Count	310	162	50	522		Asymp. Sig. (2-sided) .002
	% within Marital Status	59.4	31.0	9.6	100		
Unmarried	Count	13	2	0	15		
	% within Marital Status	86.7	13.3	0.0	100		
Single (Widow/ Widower)	Count	43	35	20	98		
	% within Marital Status	43.9	35.7	20.4	100		
Divorced	Count	0	1	0	1		
	% within Marital Status	0.0	100.0	0.0	100		
Total	Count	366	200	70	636		
	% within Marital Status	57.5	31.4	11.0	100		

Source: Field Survey, 2015.

The table 7.71 shows that respondents of having an occupation as other occupation (90.1%), jobs/service in Nepal (78.6%) were higher percentage in known and religion-wise respondents having religion as not knowing their own religion (67.5%), Buddhism (64.7%) were higher percentage in known and marital status wise unmarried (86.7%) were higher percentage in known (having knowledge and awareness) on sufficient or deficient nutritious values in junk food for their children and themselves.

The Chi-Square (χ^2) test shows that there was a significant association ($\chi^2= 30.191$, $df = 16$ and $p = .017$, which is less than .05) found between the respondents of different *occupation* wise groups in their knowledge and awareness on sufficient or deficient nutritious values in junk food for their children and themselves. Similarly, there was a significant association ($\chi^2= 19.731$, $df = 10$ and $p = .032$, which is less than .05) found between the respondents of different *religion*-wise groups in their knowledge and awareness on sufficient or deficient nutritious values in junk food for their children and themselves. And, there was a significant association ($\chi^2= 20.592$, $df = 6$ and $p = .002$, which is less than .05) found between the

respondents of different *marital status* wise groups in their knowledge and awareness on sufficient or deficient nutritious values in junk food for their children and themselves.

7.8.3 Likert Scale Distribution of Consuming Alcohol, Smoking and Personal Ethics

Smoking, alcohol and conducting bad or risky habits/ avoiding ethics, morals are also causes the illness. The three Likert scale statements are as follows:

Table 7.72: Likert Scale Statements about Consuming Alcohol, Smoking and Personal Ethics

Statements	Agree		Uncertain		Disagree		Total	
	N	%	N	%	N	%	N	%
<i>D 4. Bad morals, conduct, manner or behavior of a person could cause of illness.</i>	431	67.7	134	21.1	71	11.2	636	100
<i>D 7. Misuse of alcohol-containing beverage drinking could cause disease.</i>	611	96.1	21	3.3	4	0.6	636	100
<i>D 8. Cigarettes and tobacco are harmful to health.</i>	453	71.2	112	17.6	71	11.2	636	100

Source: Field Survey, 2015

The above three-degree response Likert Scale statements regarding knowledge in taking alcohol, smoking and ethical matters are analysed and discussed as follows:

Here, according to Kothari and Garg (2015, pp 78-80), if the instruments consists 3 statements (Likert Scale questions) and three degrees, the following score value would be revealing:

$3 \times 3 = 9$ Most of unfavourable attitudes

$3 \times 2 = 6$ neural attitudes

$3 \times 1 = 3$ Most of favourable responses

Hence, here score for any individual would fall between 3 and 9. The score above 6; it shows that having a negative perception towards causation of illness due to smoking, alcohol and breaking ethics/ avoiding morale and the score below 6 shows that having a positive perception towards causation of illness due to smoking, alcohol and breaking ethics/ avoiding morale and exactly 6 is suggestive of neutral or undecided. The Likert Scale score distribution of perception on causation illness due to smoking, alcohol and neglecting ethics, moral or bad behaviours among the Magars is presented in table 7.73:

Table 7.73: Distribution of Likert Scale score on Causation of Illness due to Smoking, Alcohol and Personal Ethics/habit

Score	Causation of Illness due to Smoking, Alcohol and Personal Ethics			
	Frequency	Percent	Valid Percent	Cumulative Percent
3.00	277	43.6	43.6	43.6
4.00	189	29.7	29.7	73.3
5.00	146	23.0	23.0	96.2
6.00	18	2.8	2.8	99.1
7.00	6	0.9	0.9	100.0
8.00	0	0.0	0.0	
9.00	0	0.0	0.0	
Total	636	100.0	100.0	

Source: Field Survey, 2015.

The table 7.73 shows that, 43.6% percentage respondents were extremely agreed with the Likert Scale statements and 96.2% respondents were positively agreed with the statements. There were not extremely disagreed respondents, however, 0.9% of respondents disagreed with the Likert Scale statements and 2.8% of respondents were uncertain about the statements of causation of illness due to alcohol, smoking, breaking ethic or moral and bad performing personal habits.

7.8.4 Likert Scale Distribution of Knowledge on Nutrition of Foods

In villages, there is an increasing trend of shifting from traditional foods system to junk food. The custom of giving yogurt, milk, skimmed milk (*mahi*) is decreasing and shifting by the junk food drinks such as *Coca-Cola*, *Pepsi*, *Redbull* and so on. The Likert Scale statements about the knowledge of nutrition values at traditional food and junk foods are given in table 7.74:

Table 7.74: Likert Scale Statements about knowledge of nutrition within available foods

Statements	Agree		Uncertain		Disagree		Total	
	N	%	N	%	N	%	N	%
<i>D 9. Our traditional foods (e.g. dhindo, anto, bread, arum leaf, nettle, etc.) are more nutritious than today's junk food.</i>	589	92.6	43	6.8	4	0.6	636	100
<i>D 10. Today's prevailing junk foods (e.g. instant noodles, Pepsi, soft drinks like Coca-Cola, Pepsi, potato chips, etc. packed foods) are not beneficial for good health.</i>	495	77.8	110	17.3	31	4.9	636	100

Source: Field Survey, 2015

The above three-degree responses Likert Scale statements are analysed and the result is discussed as follows:

According to Kothari and Garg (2015, pp 78-80), if the instruments consists 2 statements (Likert Scale questions) and three degrees, the following score value would be revealing:

2 x 3 = 6 Most of unfavourable attitudes

2 x 2 = 4 neutral attitudes

2 x 1 = 2 Most of favourable responses

Hence, here score for any individual would fall between 2 and 6. The score above 4; it shows that having negative perception towards nutritious values on traditional and junk foods and the score below 4 shows that having a positive perception towards nutritious values on traditional and junk foods and exactly 4 is suggestive of neutral or undecided. The Likert Scale score distribution of knowledge towards nutritious values on traditional and junk foods among the Magars is presented in table 7.75:

Table 7.75: Distribution of Likert Scale Score on Knowledge towards Nutrition Values at Traditional and Junk food

Score	Nutrition Values on Traditional and Junk food			
	Frequency	Percent	Valid Percent	Cumulative Percent
2.00	464	73.0	73.0	73.0
3.00	128	20.1	20.1	93.1
4.00	39	6.1	6.1	99.2
5.00	3	0.5	0.5	99.7
6.00	2	0.3	0.3	100.0
Total	636	100.0	100.0	

Source: Field Survey, 2015.

The table 7.75 shows that, 73% of respondents were agreed more about the nutrition values of traditional food and junk food for good health, and cumulatively, 93.1% of respondents are agreed with the Likert Scale statements. Only, 0.3% respondents were extremely disagreed with Likert Scale statements and 0.8% of respondents were disagree with Likert Scale statements. The 6.1% of respondents were neutral or undecided about the Likert statements related to knowledge towards about the nutrition values of traditional food and junk food for good health.

7.9 Occupational Health

7.9.1 Perception towards Occupational Health

Health and safety are essential for the occupation and doing the works. Occupational health deals with all aspects of health and safety in the workplace and has a strong focus on primary prevention of hazards. The health of the workers has several determinants, including risk factors at the workplace leading to cancers, accidents, musculoskeletal diseases, respiratory diseases, hearing loss, circulatory diseases, stress-related disorders and communicable diseases and others (http://www.who.int/topics/occupational_health/en/ Aug 2018). Taking simple precautions, many incidents could be prevented. The knowledge and attitude about occupational health among the Magars are discussed here.

The education and marital status wise views and associations on taking precaution for occupational health is presented in table 7.76:

Table 7.76: Education and Marital Status-wise Perception in Taking Precaution for Occupational Health

Education Level		Response			Total	Pearson Chi-Square	
		Agree	Uncertain	Disagree			
Illiterate	Count	79	10	0	89	Asymp. Sig. (2-sided) .000	
	% within Education	88.8	11.2	0.0	100		
Literate/ Primary	Count	267	8	0	275		
	% within Education	97.1	2.9	0.0	100		
Lower Secondary	Count	99	2	0	101		
	% within Education	98.0	2.0	0.0	100		
Secondary	Count	112	3	0	115		
	% within Education	97.4	2.6	0.0	100		
Certificate Level/+2	Count	40	0	0	40		
	% within Education	100.0	0.0	0.0	100		
Bachelor & above	Count	14	1	1	16		
	% within Education	87.5	6.3	6.3	100		
Total	Count	611	24	1	636		
	% within Education	96.1	3.8	0.2	100		
Marital Status							
Married	Count	508	13	1	522		Asymp. Sig. (2-sided) .006
	% within Marital Status	97.3	2.5	0.2	100		
Unmarried	Count	15	0	0	15		
	% within Marital Status	100.0	0.0	0.0	100		
Single (Widow/ Widower)	Count	87	11	0	98		
	% within Marital Status	88.8	11.2	0.0	100		
Divorced	Count	1	0	0	1		
	% within Marital Status	100.0	0.0	0.0	100		
Total	Count	611	24	1	636		
	% within Marital Status	96.1	3.8	0.2	100		

Source: Field survey, 2015.

The table 7.76 shows that the majority of respondents (96.1%) were found agreed with taking simple precautions for doing work could prevent illness and 3.8% of respondents were uncertain about the occupational health statement of the survey. Education level-wise, respondents of illiterate groups (11.2%) were higher percentage in an uncertain and marital status wise single (widow/widower) (11.2%) were higher percentage in uncertain about the taking precaution for occupational health.

The Chi-Square (χ^2) test shows that there was a significant association ($\chi^2= 56.244$, $df = 10$ and $p = .000$, which is less than .05) found between the respondents of different *education level*-wise groups in their perception of agreeing on taking precaution in occupational health for prevention illness. Similarly, there was a significant association ($\chi^2= 18.170$, $df = 6$ and $p = .006$, which is less than .05) found between the respondents of different *marital status* wise groups in their perception of agreeing on taking precaution in occupational health for prevention illness.

The occupation wise views and associations on taking precaution for occupational health is presented in table 7.77:

Table 7.77: Perception in Taking Precaution for Occupational Health by Occupation

Occupation		Response			Total	Pearson Chi-Square
		Agree	Uncertain	Disagree		
Agriculture	Count	322	16	0	338	Asymp. Sig. (2-sided) .000
	% within Occupation	95.3	4.7	0.0	100	
Job/ service in Nepal	Count	28	0	0	28	
	% within Occupation	100.0	0.0	0.0	100	
Construction/ Maintenance works	Count	20	0	0	20	
	% within Occupation	100.0	0.0	0.0	100	
Business	Count	32	1	0	33	
	% within Occupation	97.0	3.0	0.0	100	
Foreign Employment	Count	30	2	0	32	
	% within Occupation	93.8	6.3	0.0	100	
Job in India	Count	22	1	0	23	
	% within Occupation	95.7	4.3	0.0	100	
House wife	Count	44	1	0	45	
	% within Occupation	97.8	2.2	0.0	100	
Ex-Army/Pensioner/Army in India or UK	Count	104	3	0	107	
	% within Occupation	97.2	2.8	0.0	100	
Others	Count	9	0	1	10	
	% within Occupation	90.0	0.0	10.0	100	
Total	Count	611	24	1	636	
	% within Occupation	96.1	3.8	0.2	100	

Source: Field survey, 2015.

The table 7.77 shows that respondent's occupation having job/service in Nepal (100%), construction/ maintenance works (100%) were higher percentage in agree and respondents from foreign employment (6.3%), agriculture (4.7%) were higher percentage in uncertain about the taking precaution in working for preventing illness in occupational health.

The Chi-Square (χ^2) test shows that there was a significant association ($\chi^2= 66.944$, $df = 16$ and $p = .000$, which is less than .05) found between the respondents of different *occupation* wise groups in their perception of agreeing on taking precaution in occupational health for prevention illness.

The income source of household wise views on taking precaution for occupational health is presented in table 7.78:

Table 7.78: Perception in taking Precaution for Occupational Health by Income Source of Household

Income Source of Household		Response			Total	Pearson Chi-Square
		Agree	Uncertain	Disagree		
Agriculture	Count	74	1	0	75	Asymp. Sig. (2-sided) .002
	%	98.7	1.3	0.0	100	
Agriculture, labour or wage's works, Skill works	Count	34	1	0	35	
	%	97.1	2.9	0.0	100	
Agriculture, Private Job in India or equivalence	Count	63	5	0	68	
	%	92.6	7.4	0.0	100	
Agriculture, Business/ small Entrepreneurships	Count	27	1	0	28	
	%	96.4	3.6	0.0	100	
Agriculture, Service/ Jobs in other sectors	Count	18	2	0	20	
	%	90.0	10.0	0.0	100	
Agriculture, teacher/Nepal Army/Police/Govt. Job/Pension	Count	55	0	0	55	
	%	100.0	0.0	0.0	100	
Other sources not including Agriculture (e.g. Job, foreign employment, Business etc)	Count	42	0	0	42	
	%	100.0	0.0	0.0	100	
Agriculture, Foreign employment (Gulf, Malaysia or equivalent)	Count	118	7	0	125	
	%	94.4	5.6	0.0	100	
Agriculture, Indian Army/police or Pension	Count	154	7	0	161	
	%	95.7	4.3	0.0	100	
Agriculture, Foreign Employment (Korea, Afghanistan, Iraq, Europe, America or equivalent)	Count	19	0	1	20	
	%	95.0	0.0	5.0	100	
Agriculture, British Army/Singapore Police or Pensioner	Count	7	0	0	7	
	%	100.0	0.0	0.0	100	
Total	Count	611	24	1	636	
	%	96.1	3.8	0.2	100	

Source: Field Survey, 2015.

The table 7.78 shows that respondents having income source of households as Agriculture with service/ jobs in other sectors (10%) were higher percentage in uncertain and Agriculture with teacher/Nepal army/police/govt. job/pension (100%), Other sources not including

agriculture (e.g. job, foreign employment, business etc) (100%) were higher percentage in agree on taking precaution at working could prevent from the illness or injuries.

The Chi-Square (χ^2) test shows that there was a significant association ($\chi^2= 42.778$, $df = 20$ and $p = .002$, which is less than .05) found between the respondents of different *occupation*-wise groups in their perception of agreeing on taking precaution in occupational health for prevention illness.

7.9.2 Discussion

Occupational health deals with all aspects of health and safety in the workplace and has a strong focus on primary prevention of hazards. Health and safety are essential in working or doing occupation to reduce risk factors at the workplace leading to cancers, accidents, musculoskeletal diseases, respiratory diseases, hearing loss, circulatory diseases, stress-related disorders and communicable diseases and others. About the precaution in working in the subject of occupational health majority respondents (96.1%) were found agreed and 3.8% respondents were uncertain about the occupational health statement of the survey with taking simple precaution for doing work could prevent from illness. Education level-wise, the respondents of illiterate groups (11.2%) were higher percentage in an uncertain and marital status wise single (widow/widower) (11.2%) were higher percentage in uncertain about the taking precaution for occupational health.

In Chi-Square (χ^2) test, there was a significant association ($\chi^2= 56.244$, $df = 10$ and $p = .000$, which is less than .05) found between the respondents of different *education level, marital status, occupation, income source of household*-wise groups in their perception of agreeing on taking precaution in occupational health for prevention illness.

7.10 Understanding of Health Institutions and Health Workers

In this section understanding, knowledge, way of thinking and feelings towards governmental health institutions, health workers, bio-medicines are discussed.

7.10.1 Knowledge about Governmental Health Institution

In the study area, there were three types of government health institutions (sub-health post, health post and primary health center) to deliver governmental health care services. The knowledge of respondents about the type or grade of governmental health institutions situated in their VDCs is discussed here. The age and education-wise analysis and result are presented table 7.79:

Table 7.79: Knowledge towards Governmental Health Institution by Age and Education

		Knowledge about Governmental Health Institutions Situated in the VDC				Pearson Chi-Square
Age of Respondents		Wrong Answer	Correct Answer	Don't Know	Total	
Under 25	Count	10	27	3	40	Asymp. Sig. (2-sided) .000
	% within Age	25.0	67.5	7.5	100	
26 - 35	Count	39	74	16	129	
	% within Age	30.2	57.4	12.4	100	
36 - 45	Count	41	66	38	145	
	% within Age	28.3	45.5	26.2	100	
46 - 55	Count	32	61	37	130	
	% within Age	24.6	46.9	28.5	100	
56 - 65	Count	30	34	47	111	
	% within Age	27.0	30.6	42.3	100	
66 & above	Count	27	23	31	81	
	% within Age	33.3	28.4	38.3	100	
Total	Count	179	285	172	636	
	% within Age	28.1	44.8	27.0	100	
Education Level of Respondents						
Illiterate	Count	25	18	46	89	Asymp. Sig. (2-sided) .000
	% within Education	28.1	20.2	51.7	100	
Literate/Primary	Count	80	117	78	275	
	% within Education	29.1	42.5	28.4	100	
Lower Secondary	Count	24	51	26	101	
	% within Education	23.8	50.5	25.7	100	
Secondary	Count	35	63	17	115	
	% within Education	30.4	54.8	14.8	100	
Certificate Level/+2	Count	9	27	4	40	
	% within Education	22.5	67.5	10.0	100	
Bachelor & above	Count	6	9	1	16	
	% within Education	37.5	56.3	6.3	100	
Total	Count	179	285	172	636	
	% within Education	28.1	44.8	27.0	100	

Source: Field Survey, 2015.

The table 7.79 shows that, 44.8% of respondents had correct knowledge about the governmental health institutions situated in their respected VDCs and 28.1% had inappropriate knowledge and 27.0% of respondents had no idea (Don't know) about the health institutions. The younger age and higher education level respondents were found having knowledge about the governmental health institution situated in their respective VDCs.

The Chi-Square (χ^2) test shows that, there was a significant association ($\chi^2= 50.260$, $df = 10$ and $p = .000$, which is less than .05) found between the respondents of different *age-wise* groups in their knowledge on governmental health institutions situated in respected VDCs. Similarly, there was a significant association ($\chi^2= 56.075$, $df = 10$ and $p = .000$, which is less than .05) found between the respondents of different *education level-wise* groups in their knowledge on governmental health institutions situated in respected VDCs

The occupation and marital status-wise knowledge and associations towards governmental health institution situated their own respective VDCs is presented in table 7.80:

Table 7.80: Knowledge towards Governmental Health Institutions by Occupation and Marital Status

Occupation		Response			Total	Pearson Chi-Square
		Wrong Answer	Correct Answer	Don't Know		
Agriculture	Count	94	153	91	338	Asymp. Sig. (2-sided) .000
	% within Occupation	27.8	45.3	26.9	100	
Job/ service in Nepal	Count	10	16	2	28	
	% within Occupation	35.7	57.1	7.1	100	
Construction/ Maintenance works	Count	5	12	3	20	
	% within Occupation	25.0	60.0	15.0	100	
Business	Count	11	17	5	33	
	% within Occupation	33.3	51.5	15.2	100	
Foreign Employment	Count	8	14	10	32	
	% within Occupation	25.0	43.8	31.3	100	
Job in India	Count	7	10	6	23	
	% within Occupation	30.4	43.5	26.1	100	
House wife	Count	14	25	6	45	
	% within Occupation	31.1	55.6	13.3	100	
Ex-Army/Pensioner/ Army in India or UK	Count	28	30	49	107	
	% within Occupation	26.2	28.0	45.8	100	
Others	Count	2	8	0	10	
	% within Occupation	20.0	80.0	0.0	100	
Total	Count	179	285	172	636	
	% within Occupation	28.1	44.8	27.0	100	
Marital Status						
Married	Count	154	243	125	522	Asymp. Sig. (2-sided) .000
	% within Marital Status	29.5	46.6	23.9	100	
Unmarried	Count	3	12	0	15	
	% within Marital Status	20.0	80.0	0.0	100	

Single (Widow/Widower)	Count	22	30	46	98
	% within Marital Status	22.4	30.6	46.9	100
Divorced	Count	0	0	1	1
	% within Marital Status	0.0	0.0	100	100
Total	Count	179	285	172	636
	% within Marital Status	28.1	44.8	27.0	100

Source: Field Survey, 2015.

The table 7.80 shows that, the respondents having other professions (80%), construction and maintenance work (60%), job/service with Nepal (57.1%) were higher percentage and marital status wise respondents of unmarried groups (80%) were found higher percentage in having knowledge about the government health institutions in their own VDC.

The Chi-Square (χ^2) test shows that, there was a significant association ($\chi^2= 41.495$, $df = 16$ and $p = .000$, which is less than .05) found between the respondents of different *occupation* wise groups in their knowledge on governmental health institutions situated in respected VDCs. Similarly, there was a significant association ($\chi^2= 33.681$, $df = 6$ and $p = .000$, which is less than .05) found between the respondents of different *marital status* wise groups in their knowledge on governmental health institutions situated in respected VDCs.

7.10.2 Knowledge of Free Medicine through Governmental Health Institution

The government of Nepal is distributing free medicine from governmental health institutions. The governmental sub-health post distributed 25 kinds of essential medicines, health post distributed 35 kinds of essential medicines and primary health center (PHC) and district hospital distributed 40 kinds of essential medicine in free of cost for public health care (GoN, MoH&P, June 2012, p.1). However, currently, the number of free distribution of medicine is increased up to 70 items. Here, the understanding of free medicine and health services in the governmental health institution of Magars respondents analysed and result is presented in table 7.81:

Table 7.81: Knowledge towards Freely Available Medicines by Education and Age

Education		Response			Total	Pearson Chi- Square
		Wrong Answer	Correct Answer	Don't Know		
Illiterate	Count	9	5	75	89	Asymp. Sig. (2- sided) .000
	% within Education	10.1	5.6	84.3	100	
Literate/ Primary	Count	44	20	211	275	
	% within Education	16.0	7.3	76.7	100	
Lower Secondary	Count	19	18	64	101	
	% within Education	18.8	17.8	63.4	100	
Secondary	Count	24	21	70	115	
	% within Education	20.9	18.3	60.9	100	
Certificate	Count	6	10	24	40	

Level/+2	% within Education	15.0	25.0	60.0	100	
Bachelor & above	Count	5	2	9	16	
	% within Education	31.3	12.5	56.3	100	
Total	Count	107	76	453	636	
	% within Education	16.8	11.9	71.2	100	
Age of respondents						
Under 25	Count	6	5	29	40	Asymp. Sig. (2- sided) .027
	% within Age	15.0	12.5	72.5	100	
26 - 35	Count	29	24	76	129	
	% within Age	22.5	18.6	58.9	100	
36 - 45	Count	28	20	97	145	
	% within Age	19.3	13.8	66.9	100	
46 - 55	Count	20	12	98	130	
	% within Age	15.4	9.2	75.4	100	
56 - 65	Count	12	8	91	111	
	% within Age	10.8	7.2	82.0	100	
66 & above	Count	12	7	62	81	
	% within Age	14.8	8.6	76.5	100	
Total	Count	107	76	453	636	
	% within Age	16.8	11.9	71.2	100	

Source: Field Survey, 2015.

The table 7.81 shows that, only 11.9% of Magars respondents had knowledge about the government's free medicine scheme available in respected governmental health institutions and a majority 71.2% have no idea about it. The low education level and higher aged group population have low knowledge about the freely available medicines in the governmental institutions.

The Chi-Square (χ^2) test shows that, there was a significant association ($\chi^2= 33.494$, $df = 10$ and $p = .000$, which is less than .05) found between the respondents of different *education level*-wise groups in their knowledge on freely available medicines into governmental health institutions situated in respected VDCs. Similarly, there was a significant association ($\chi^2= 20.220$, $df = 10$ and $p = .027$, which is less than .05) found between the respondents of different *age*-wise groups in their knowledge on freely available medicines into governmental health institutions situated in respected VDCs.

The marital status and religion-wise knowledge of respondents and associations towards government provided facilities of free medicine available in the local health institution is presented in table 7.82:

Table 7.82: Knowledge towards Freely Available Medicine in a Governmental Health Institution by Marital Status and Religion

Marital Status		Response			Total	Pearson Chi-Square	
		Wrong Answer	Correct Answer	Don't Know			
Married	Count	91	68	363	522	Asymp. Sig. (2-sided) .035	
	% within Marital Status	17.4	13.0	69.5	100		
Unmarried	Count	5	3	7	15		
	% within Marital Status	33.3	20.0	46.7	100		
Single (Widow/Widower)	Count	11	5	82	98		
	% within Marital Status	11.2	5.1	83.7	100		
Divorced	Count	0	0	1	1		
	% within Marital Status	0.0	0.0	100.0	100		
Total	Count	107	76	453	636		
	% within Marital Status	16.8	11.9	71.2	100		
Religion							
Traditional or Animist	Count	17	13	116	146		Asymp. Sig. (2-sided) .008
	% within Religion	11.6	8.9	79.5	100		
Buddhist	Count	10	19	56	85		
	% within Religion	11.8	22.4	65.9	100		
Hindu	Count	75	40	241	356		
	% within Religion	21.1	11.2	67.7	100		
Christian	Count	2	0	5	7		
	% within Religion	28.6	0.0	71.4	100		
Atheism /Nastik	Count	0	0	2	2		
	% within Religion	0.0	0.0	100.0	100		
Don't Know	Count	3	4	33	40		
	% within Religion	7.5	10.0	82.5	100		
Total	Count	107	76	453	636		
	% within Religion	16.8	11.9	71.2	100		

Source: Field Survey, 2015.

The table 7.82 shows that marital status wise respondents of unmarried (20%) were a higher percentage in having knowledge about the freely available medicines in governmental health institutions. Similarly, religion-wise Buddhist (22.4%) were found higher percentage in having knowledge and respondents from other religions (100%), traditional or animist (79%), Hindu (67%) were found higher percentage in 'Don't know' category.

The Chi-Square (χ^2) test shows that, there was a significant association ($\chi^2= 13.552$, $df = 6$ and $p = .035$, which is less than .05) found between the respondents of different *marital status* wise groups in their knowledge on freely available medicines into governmental health institutions situated in respected VDCs. Similarly, there was a significant association ($\chi^2= 28.893$, $df = 10$ and $p = .008$, which is less than .05) found between the respondents of different *religion*-wise groups in their knowledge on freely available medicines into governmental health institutions situated in respected VDCs.

7.10.3 Knowledge of Vaccines Provided from Governmental Health Institutions

The government has been providing immunization programs for neo-natal children to prevent them from diseases like *Tuberculosis, Diphtheria, Pertussis/ whooping cough, Tetanus, Hepatitis-B, Homophiles influenza B, Polio, Pneumonia, Measles and Rubella, Japanese Encephalitis*. Immunization/ vaccination program is a regular schedule of the government and ministry of health and population. Here, knowledge towards vaccination and covered disease by the immunization which is run by the governmental health institution in the villages of Magar respondents is analysed and discussed.

The age and education-wise analysis and the results of respondent's knowledge about vaccines are presented in table 7.83:

Table 7.68: Knowledge about the Vaccination by Age and Education

Age	Vaccination Against the Diseases				Total	Pearson Chi-Square
	Against 10 types of diseases	Against 06 types of diseases	Against 04 types of diseases	Don't Know		
Under 25	Count	2	10	11	17	Asymp. Sig. (2-sided) .001
	%	5.0	25.0	27.5	42.5	
26 - 35	Count	11	33	37	48	
	%	8.5	25.6	28.7	37.2	
36 - 45	Count	3	35	35	72	
	%	2.1	24.1	24.1	49.7	
46 - 55	Count	3	29	32	66	
	%	2.3	22.3	24.6	50.8	
56 - 65	Count	4	19	16	72	
	%	3.6	17.1	14.4	64.9	
66 & above	Count	1	9	15	56	
	%	1.2	11.1	18.5	69.1	
Total	Count	24	135	146	331	
	%	3.8	21.2	23.0	52.0	
Education Level						
Illiterate	Count	4	11	9	65	Asymp. Sig. (2-sided) .000
	%	4.5	12.4	10.1	73.0	
Literate/Primary	Count	6	52	63	154	
	%	2.2	18.9	22.9	56.0	
Lower Secondary	Count	5	19	26	51	
	%	5.0	18.8	25.7	50.5	
Secondary	Count	3	34	33	45	
	%	2.6	29.6	28.7	39.1	
Certificate Level/+2	Count	1	15	14	10	
	%	2.5	37.5	35.0	25.0	
Bachelor & above	Count	5	4	1	6	
	%	31.3	25.0	6.3	37.5	
Total	Count	24	135	146	331	
	%	3.8	21.2	23.0	52.0	

Source: Field Survey, 2015.

The table 7.83 shows majority of respondents (52%) had no idea about the vaccination/ immunization and protection of diseases. Only 3.8% of respondents contained knowledge about the recent vaccination programs and 21.2% told only 6 kinds of diseases. The knowledge about the vaccination/ immunization was found young age group and higher education level had higher knowledge and awareness than lower-level education and older age.

The Chi-Square (χ^2) test shows that, there was a significant association ($\chi^2= 39.068$, $df = 15$ and $p = .001$, which is less than .05) found between the respondents of different *age-wise* groups in their knowledge on vaccination and protection of diseases which was provided by the governmental health institutions situated in respected VDCs. Similarly, there was significant association ($\chi^2= 79.294$, $df = 15$ and $p = .000$, which is less than .05) found between the respondents of different *education level-wise* groups in their knowledge on vaccination and protection of diseases which was provided by the governmental health institutions situated in respected VDCs.

The occupation wise and marital status-wise knowledge and association toward vaccination/ immunization is presented in table 7.85:

Table 7.85: Knowledge about the Vaccination by Occupation and Marital Status

Occupation		Response				Total	Pearson Chi-Square
		Against 10 types of diseases	Against 06 types of diseases	Against 04 types of diseases	Don't Know		
Agriculture	Count	11	75	68	184	338	Asymp. Sig. (2-sided) .001
	%	3.3	22.2	20.1	54.4	100	
Job/ Service in Nepal	Count	4	7	8	9	28	
	%	14.3	25.0	28.6	32.1	100	
Construction/ Maintenance work	Count	2	3	6	9	20	
	%	10.0	15.0	30.0	45.0	100	
Business	Count	1	13	7	12	33	
	%	3.0	39.4	21.2	36.4	100	
Foreign Employment	Count	1	7	10	14	32	
	%	3.1	21.9	31.3	43.8	100	
Job in India	Count	0	1	11	11	23	
	%	0.0	4.3	47.8	47.8	100	
Housewife	Count	2	11	18	14	45	
	%	4.4	24.4	40.0	31.1	100	
Ex-Army/Pensioner/ Army in India or Uk	Count	3	17	16	71	107	
	%	2.8	15.9	15.0	66.4	100	
Others	Count	0	1	2	7	10	
	%	0.0	10.0	20.0	70.0	100	
Total	Count	24	135	146	331	636	
	%	3.8	21.2	23.0	52.0	100	
Marital Status							
Married	Count	20	117	130	255	522	Asymp.

	%	3.8	22.4	24.9	48.9	100	Sig. (2-sided) .021
Unmarried	Count	2	4	2	7	15	
	%	13.3	26.7	13.3	46.7	100	
Single (Widow/ Widower)	Count	2	14	14	68	98	
	%	2.0	14.3	14.3	69.4	100	
Divorced	Count	0	0	0	1	1	
	%	0.0	0.0	0.0	100.0	100	
Total	Count	24	135	146	331	636	
	%	3.8	21.2	23.0	52.0	100	

Source: Field Survey, 2015.

The table 7.85 shows occupation-wise jobs/ service having in Nepal (14.3%) and unmarried (13.3%) were found higher percentage in having knowledge about the vaccination/ immunization program.

The Chi-Square (χ^2) test shows that, there was a significant association ($\chi^2= 104.260$, $df = 51$ and $p = .000$, which is less than .05) found between the respondents of different *occupation* wise groups in their knowledge on vaccination and protection of diseases which was provided by the governmental health institutions situated in respected VDCs. Similarly, there was a significant association ($\chi^2= 19.566$, $df = 9$ and $p = .021$, which is less than .05) found between the respondents of different *marital status* wise groups in their knowledge on vaccination and protection of diseases which was provided by the governmental health institutions situated in respected VDCs.

7.10.4 Knowledge about the Qualification of Health Workers

The knowledge about the health worker's qualification helps to understand the limitation of the health care services at a local level. The knowledge about the qualification ranks of governmental health institutions of Magar respondents are discussed here.

The education level and age-wise analysis and result are presented in table 7.86:

Table 7.86: Knowledge about the Qualification and Ranks of Governmental Health Institutions by Education and Age

Education level		Response		Total	Pearson Chi-Square
		Known	Unknown		
Illiterate	Count	8	81	89	Asymp. Sig. (2-sided) .000
	% within Education	9.0	91.0	100	
Literate/ Primary	Count	46	229	275	
	% within Education	16.7	83.3	100	
Lower Secondary	Count	20	81	101	
	% within Education	19.8	80.2	100	
Secondary	Count	38	77	115	
	% within Education	33.0	67.0	100	
Certificate	Count	13	27	40	

Level/+2	% within Education	32.5	67.5	100		
Bachelor & above	Count	8	8	16		
	% within Education	50.0	50.0	100		
Total	Count	133	503	636		
	% within Education	20.9	79.1	100		
Age of Respondent						
Under 25	Count	9	31	40	Asymp. Sig. (2- sided) .000	
	% within Age	22.5	77.5	100		
26 - 35	Count	40	89	129		
	% within Age	31.0	69.0	100		
36 - 45	Count	39	106	145		
	% within Age	26.9	73.1	100		
46 - 55	Count	23	107	130		
	% within Age	17.7	82.3	100		
56 - 65	Count	14	97	111		
	% within Age	12.6	87.4	100		
66 & above	Count	8	73	81		
	% within Age	9.9	90.1	100		
Total	Count	133	503	636		
	% within Age	20.9	79.1	100		

Source: Field Survey, 2015.

The table 7.86 shows, that only 20.9% of Magar respondents were known about the qualifications and ranks of the health workers who are working at governmental health institutions and the majority 89.1% Magar respondents had no idea or knowledge. The having higher education respondents and younger age or 26- 45 years respondents were found having higher knowledge about the detail of staffs of governmental health institutions.

The Chi-Square (χ^2) test shows that, there was a significant association ($\chi^2= 32.304$, $df = 5$ and $p = .000$, which is less than .05) found between the respondents of different *education level*-wise group in their knowledge on qualification and ranks of staffs of the governmental health institutions situated in respected VDCs. Similarly, there was a significant association ($\chi^2= 22.553$, $df = 5$ and $p = .000$, which is less than .05) found between the respondents of different *age* wise group in their knowledge on qualification and ranks of staffs of the governmental health institutions situated in respected VDCs.

7.10.5 Views on Effectiveness of Health Care Services of Governmental Health Institutions

The peoples have their own views and judgement about the delivery of health care services in their location. Here, the views of respondents on effective service delivery from the governmental health institution of their VDCs are discussed.

The age-wise and education level-wise understanding for effectiveness of delivery of health care services from the local governmental health institutions is presented in table 7.86:

Table 7.86: Views on Effective Delivery of Health Services by Age and Education

Age		Response			Total	Pearson Chi-Square	
		Yes	No	Don't Know			
Under 25	Count	9	26	5	40	Asymp. Sig. (2-sided) .000	
	% within Age	22.5	65.0	12.5	100		
26 - 35	Count	31	59	39	129		
	% within Age	24.0	45.7	30.2	100		
36 - 45	Count	31	61	53	145		
	% within Age	21.4	42.1	36.6	100		
46 - 55	Count	26	68	36	130		
	% within Age	20.0	52.3	27.7	100		
56 - 65	Count	13	39	59	111		
	% within Age	11.7	35.1	53.2	100		
66 & above	Count	10	27	44	81		
	% within Age	12.3	33.3	54.3	100		
		Count	120	280	236		636
		% within Age	18.9	44.0	37.1		100
Education Level							
Illiterate	Count	8	37	44	89	Asymp. Sig. (2-sided) .000	
	% within Education	9.0	41.6	49.4	100		
Literate/ Primary	Count	44	113	118	275		
	% within Education	16.0	41.1	42.9	100		
Lower Secondary	Count	21	41	39	101		
	% within Education	20.8	40.6	38.6	100		
Secondary	Count	31	59	25	115		
	% within Education	27.0	51.3	21.7	100		
Certificate Level/+2	Count	13	22	5	40		
	% within Education	32.5	55.0	12.5	100		
Bachelor & above	Count	3	8	5	16		
	% within Education	18.8	50.0	31.3	100		
Total		Count	120	280	236		636
		% within Education	18.9	44.0	37.1		100

Source: Field Survey, 2015.

The table 7.86 shows, respondents having higher education, younger age groups were more dissatisfied about health care service delivery of local governmental health institution.

The Chi-Square (χ^2) test shows that, there was a significant association ($\chi^2= 43.804$, $df = 10$ and $p = .000$, which is less than .05) found between the respondents of different *age*-wise groups, in their views on effective health care service delivery through the governmental health institutions situated in their respected VDCs. Similarly, there was a significant association ($\chi^2= 37.837$, $df = 10$ and $p = .000$, which is less than .05) found between the respondents of different *education level*-wise groups, in their views on effective health care service delivery through the governmental health institutions situated in their respected VDCs

The occupation-wise understandings and association for effectiveness of delivery of health care services from the local governmental health institutions results are presented in Table 7.87:

Table 7.87: Views on Effective Delivery of Health Services by Occupation

Occupation		Response			Total	Pearson Chi-Square
		Yes	No	Don't Know		
Agriculture	Count	69	142	127	338	Asymp. Sig. (2-sided) .000
	% within Occupation	20.4	42.0	37.6	100	
Job/ Service in Nepal	Count	11	13	4	28	
	% within Occupation	39.3	46.4	14.3	100	
Construction/ Maintenance works	Count	3	12	5	20	
	% within Occupation	15.0	60.0	25.0	100	
Business	Count	6	21	6	33	
	% within Occupation	18.2	63.6	18.2	100	
Foreign Employment	Count	2	16	14	32	
	% within Occupation	6.3	50.0	43.8	100	
Job in India	Count	1	10	12	23	
	% within Occupation	4.3	43.5	52.2	100	
Housewife	Count	16	17	12	45	
	% within Occupation	35.6	37.8	26.7	100	
Ex-Army/ Pensioner/ Army in India or UK	Count	10	43	54	107	
	% within Occupation	9.3	40.2	50.5	100	
Others	Count	2	6	2	10	
	% within Occupation	20.0	60.0	20.0	100	
Total	Count	120	280	236	636	
	% within Occupation	18.9	44.0	37.1	100	

Source: Field Survey, 2015.

The table 7.87 shows, 18.9% were satisfied from the service of the local governmental health institutions, 44% were dissatisfied and 37.1% had no idea about the effectiveness or quality of health care from the local governmental health institution. Occupation-wise respondents, having job/services in Nepal (39.3%) were in higher percentage with satisfied views on effectiveness or quality of health care from the local governmental health institution.

The Chi-Square (χ^2) test shows that, there was a significant association ($\chi^2 = 46.844$, $df = 16$ and $p = .000$, which is less than .05) found between the respondents of different *occupation* wise group, in their views on effective health care service delivery through the governmental health institutions situated in their respected VDCs.

7.10.5.1 Views on Un-effectiveness of Health Care Services

In the survey, 44% (or 280) respondents told their views on un-effective health care service delivery through the governmental health institution which is situated in their VDCs. The reason for telling un-effective health care service delivery from the respondents is analysed and discussed here. And, the result is presented in table 7.88:

Table 7.88: Cause to Ineffective Health Care Service through Governmental Health Institution in their VDCs

VDC		Response							Total	Pears on Chi-Square
		Irregular presence of trained health worker in the institutions	Due to not opening 24 hourly	Rude/Irritating behaviour of health workers	Deficiency of medicines	Low quality of treatment	Being far distance	Don't Know		
Alam Devi	Count	9	5	9	19	12	2	0	56	Asym p. Sig. (2-sided) .000
	%	16.1	8.9	16.1	33.9	21.4	3.6	0.0	100	
Birgha	Count	1	10	1	18	7	1	0	38	
	%	2.6	26.3	2.6	47.4	18.4	2.6	0.0	100	
ChandiBhanjyang	Count	8	5	2	3	2	13	0	33	
	%	24.2	15.2	6.1	9.1	6.1	39.4	0.0	100	
Jagatra Devi	Count	0	9	1	18	5	6	0	39	
	%	0.0	23.1	2.6	46.2	12.8	15.4	0.0	100	
Malungga	Count	2	2	1	3	0	0	1	9	
	%	22.2	22.2	11.1	33.3	0.0	0.0	11.1	100	
Nibuwa Kharka	Count	7	2	2	0	2	4	2	19	
	%	36.8	10.5	10.5	0.0	10.5	21.1	10.5	100	
Pelakot	Count	2	3	1	0	2	11	0	19	
	%	10.5	15.8	5.3	0.0	10.5	57.9	0.0	100	
PindiKhola	Count	2	1	3	0	0	11	0	17	
	%	11.8	5.9	17.6	0.0	0.0	64.7	0.0	100	
Shree Krishna Gandaki	Count	15	9	3	7	10	5	1	50	
	%	30.0	18.0	6.0	14.0	20.0	10.0	2.0	100	
Total	Count	46	46	23	68	40	53	4	280	
	%	16.4	16.4	8.2	24.3	14.3	18.9	1.4	100	

Source: Field Survey, 2015.

The table 7.88 shows, among the respondents dissatisfied with service delivery of governmental health institution; 24.3% of respondents told deficiency of medicine at health institution, 16.4% of respondents told irregular presence of trained health workers in the institutions, 16.4% not regular and always opening and unavailable in an emergency, 18.9% respondents told far away situated governmental health institution, 14.3% respondents question raised quality of service, 8.2% respondents were told rude/irritating behaviours or unusual behaviours of government health workers. VDC-wise, the respondents of Pindikhola (64%) Pelakot (57.9%) were higher percentage in far distance situated health institutions from the villages.

The Chi-Square (χ^2) test shows that, there was a significant association ($\chi^2= 164.412$, $df = 48$ and $p = .000$, which is less than .05) found between the respondents of different VDC-wise groups, in their views on the reason of un-effective health care service delivery through the governmental health institutions situated in their respected VDCs.

7.10.6 Understanding Level of Counselling or Instructions Provided by Health Workers

Understanding of counselling or advice provided through health workers is essential for effective healings, prevention and cure of diseases. The used language, gesture, instructing methods also play the role in instructions or counselling. The understanding level of respondents in health worker's counselling and instructions is discussed here.

The age group and education level-wise level of understanding and association about counselling, instructions provided by health workers are presented in table 7.89:

Table 7.89: Understanding Level of Counselling or Instructions by Age and Education

Age		Response			Total	Pearson Chi-Square
		Understand clearly	Understand partially	Difficult to understand		
Under 25	Count	26	13	1	40	Asymp. Sig. (2-sided) .000
	% within Age	65.0	32.5	2.5	100	
26 - 35	Count	84	42	3	129	
	% within Age	65.1	32.6	2.3	100	
36 - 45	Count	80	50	15	145	
	% within Age	55.2	34.5	10.3	100	
46 - 55	Count	55	63	12	130	
	% within Age	42.3	48.5	9.2	100	
56 - 65	Count	47	49	15	111	
	% within Age	42.3	44.1	13.5	100	
66 & above	Count	23	42	16	81	
	% within Age	28.4	51.9	19.8	100	
Total	Count	315	259	62	636	
	% within Age	49.5	40.7	9.7	100	
Education						
Illiterate	Count	22	40	27	89	Asymp. Sig. (2-sided) .000
	% within Education	24.7	44.9	30.3	100	
Literate/ Primary	Count	116	138	21	275	
	% within Education	42.2	50.2	7.6	100	
Lower Secondary	Count	62	30	9	101	
	% within Education	61.4	29.7	8.9	100	
Secondary	Count	76	35	4	115	
	% within Education	66.1	30.4	3.5	100	
Certificate Level/+2	Count	27	12	1	40	
	% within Education	67.5	30.0	2.5	100	
Bachelor & above	Count	12	4	0	16	
	% within Education	75.0	25.0	0.0	100	
Total	Count	315	259	62	636	
	% within Education	49.5	40.7	9.7	100	

Source: Field Survey, 2015.

The Table No 7.89 shows that higher education level of respondents and younger age-group had a higher level of understanding of counselling and instruction provided by the government health workers than the lower education level and higher age group respectively.

The Chi-Square (χ^2) test shows that, there was a significant association ($\chi^2= 47.348$, $df = 10$ and $p = .000$, which is less than .05) found between the respondents of different *age* wise group in their level of understanding on counselling or instruction provided by health workers of the governmental health institutions situated in respected VDCs. Similarly, there was a significant association ($\chi^2= 90.912$, $df = 10$ and $p = .000$, which is less than .05) found between the respondents of different *education level*-wise group in their level of understanding on counselling or instruction provided by health workers of the governmental health institutions situated in respected VDCs.

The occupation-wise level of understanding and association about counselling, instructions provided by health workers presented in table 7.90:

Table 7.90: Understanding Level of Counselling or Instructions by Occupation

Occupation		Response			Total	Pearson Chi-Square
		Understand clearly	Understand partially	Difficult to understand		
Agriculture	Count	143	159	36	338	Asymp. Sig. (2-sided) .000
	%	42.3	47.0	10.7	100	
Job/ Service in Nepal	Count	21	7	0	28	
	%	75.0	25.0	0.0	100	
Construction/ Maintenance works	Count	9	6	5	20	
	%	45.0	30.0	25.0	100	
Business	Count	24	8	1	33	
	%	72.7	24.2	3.0	100	
Foreign Employment	Count	19	12	1	32	
	%	59.4	37.5	3.1	100	
Job in India	Count	11	10	2	23	
	%	47.8	43.5	8.7	100	
Housewife	Count	31	13	1	45	
	%	68.9	28.9	2.2	100	
Ex-Army/Pensioner/ Army in India or UK	Count	49	42	16	107	
	%	45.8	39.3	15.0	100%	
Others	Count	8	2	0	10	
	%	80.0	20.0	0.0	100	
Total	Count	315	259	62	636	
	%	49.5	40.7	9.7	100	

Source: Field Survey, 2015.

The table 7.90 shows 49.5% had clearly understood about counselling or instruction, 40.7% understands partially and 9.7% were felt difficult to understand about counselling, instructions provided by the governmental health workers.

Occupation wise respondents having other occupation (80%), job/service in Nepal (75%), business (72.7%) were higher percentage in understanding clearly and respondents having

occupation agriculture (47%), jobs in India (43.5%) were higher percentage in understanding partially of counselling or advices through governmental health institutions.

The Chi-Square (χ^2) test shows that, there was a significant association ($\chi^2= 45.020$, $df = 16$ and $p = .000$, which is less than $.05$) found between the respondents of different *occupation* wise group in their level of understanding on counselling or instruction provided by health workers of the governmental health institutions situated in respected VDCs.

Similarly, the Chi-Square (χ^2) test shows that, there was a significant association ($\chi^2= 31.584$, $df = 20$ and $p = .048$, which is less than $.05$) found between the respondents of different *income source of household* wise group in their level of understanding on counselling or instruction provided by health workers of the governmental health institutions situated in respected VDCs.

In addition, the Chi-Square (χ^2) test shows that, there was a significant association ($\chi^2= 29.814$, $df = 6$ and $p = .000$, which is less than $.05$) found between the respondents of different *marital status* wise group in their level of understanding on counselling or instruction provided by health workers of the governmental health institutions situated in respected VDCs. And, there was a significant association ($\chi^2= 29.882$, $df = 10$ and $p = .001$, which is less than $.05$) found between the respondents of different *religion*-wise group in their level of understanding on counselling or instruction provided by health workers of the governmental health institutions situated in respected VDCs.

7.10.7. Relationship with Doctors or Health Workers

The relationship between doctors (including health professionals) and patients plays a great role in healing, prevention of illness and an effective health care system. Such a relationship is also influenced from language (of service receiver and providers), communication skills of doctors (including health professionals), and various socio-cultural factors. The experiences of respondents in doctors, nurses and health workers' behaviours and relationships are discussed here.

The VDC-wise the experience of respondents and association in health worker's behaviours and relationships in visiting health institutions is presented in table 7.91:

Table 7.91: Perception towards Doctors and Health Worker's Behaviours

VDC		Response						Total	Pearson Chi-Square
		Very helpful behaviour	Generally helpful	Rude/Irritating behaviour	Discriminating behaviour	Insulting/Dominating	Don't Know		
Alamdevi	Count	21	44	12	9	0	1	87	Asymp. Sig. (2-sided) .007
	%	24.1	50.6	13.8	10.3	0.0	1.1	100	
Birgha	Count	4	45	6	9	0	0	64	
	%	6.3	70.3	9.4	14.1	0.0	0.0	100	
ChandiBhanjyang	Count	13	44	10	7	0	6	80	
	%	16.3	55.0	12.5	8.8	0.0	7.5	100	
JagatraDevi	Count	9	83	14	14	1	1	122	
	%	7.4	68.0	11.5	11.5	0.8	0.8	100	
Malungga	Count	2	16	3	5	0	1	27	
	%	7.4	59.3	11.1	18.5	0.0	3.7	100	
NibuwaKharka	Count	2	43	8	4	0	0	57	
	%	3.5	75.4	14.0	7.0	0.0	0.0	100	
Pelakot	Count	6	43	4	1	0	0	54	
	%	11.1	79.6	7.4	1.9	0.0	0.0	100	
Pindikhola	Count	1	27	6	3	0	0	37	
	%	2.7	73.0	16.2	8.1	0.0	0.0	100	
Shree Krishna Gandaki	Count	14	71	11	9	0	3	108	
	%	13.0	65.7	10.2	8.3	0.0	2.8	100	
Total	Count	72	416	74	61	1	12	636	
	%	11.3	65.4	11.6	9.6	0.2	1.9	100	

Source: Field Survey, 2015.

The table 7.91 shows that the majority Magar respondents (65.4%) had a perception of generally helpful behaviour from the doctors, nurses and health workers at governmental hospitals. The respondents of 11.6% had felt perception of rude/irritating behaviours and 9.6% respondents felt perception of doing discriminating behaviours. Similarly, 0.2% of respondents were found insulting and dominating behaviours from the doctors, nurses and health workers. The VDC-wise respondents of Pelakot (79.6%) were higher percentage in generally helpful behaviour from the doctors, nurses and health workers at governmental hospitals.

The Chi-Square (χ^2) test shows that, there was a significant association ($\chi^2= 65.559$, $df = 40$ and $p = .007$, which is less than .05) found between the respondents of different VDC wise group in their views on behaviours treated from the doctors, nurses and health workers at governmental hospitals.

7.11 Knowledge of Fundamental Health Rights in the Constitution

Nepal has protected health and health care facilities as a fundamental right in the constitution of Nepal-2015 (2072 BS). The fundamental rights about the health and right of getting health care services are also included in the Nepal Interim Constitution 2007 (2063 BS). Here, the knowledge towards fundamental rights about health and right of getting health care services among the rural Magars of the study area is discussed.

The age and education-wise distribution of knowledge towards fundamental rights of health and health care services are presented in table 7.92:

Table 7.92: Knowledge towards Fundamental Right of Health of Constitution by Age and Education

Age		Response			Total	Pearson Chi-Square
		Known	Heard only	Unknown		
Under 25	Count	8	24	8	40	Asymp. Sig. (2-sided) .000
	% within Age	20.0	60.0	20.0	100	
26 - 35	Count	21	61	47	129	
	% within Age	16.3	47.3	36.4	100	
36 - 45	Count	7	68	70	145	
	% within Age	4.8	46.9	48.3	100	
46 - 55	Count	5	47	78	130	
	% within Age	3.8	36.2	60.0	100	
56 - 65	Count	5	22	84	111	
	% within Age	4.5	19.8	75.7	100	
66 & above	Count	2	15	64	81	
	% within Age	2.5	18.5	79.0	100	
Total	Count	48	237	351	636	
	% within Age	7.5	37.3	55.2	100	
Education Level						
Illiterate	Count	2	14	73	89	Asymp. Sig. (2-sided) .000
	% within Education	2.2	15.7	82.0	100	
Literate/ Primary	Count	10	90	175	275	
	% within Education	3.6	32.7	63.6	100	
Lower Secondary	Count	7	48	46	101	
	% within Education	6.9	47.5	45.5	100	
Secondary	Count	13	58	44	115	
	% within Education	11.3	50.4	38.3	100	
Certificate Level/+2	Count	9	20	11	40	
	% within Education	22.5	50.0	27.5	100	
Bachelor & above	Count	7	7	2	16	
	% within Education	43.8	43.8	12.5	100	
Total	Count	48	237	351	636	
	% within Education	7.5	37.3	55.2	100	

Source: Field Survey, 2015.

The table 7.92 shows, that the majority of Magars respondents (55.2%) found unknown about health and health care as a fundamental right in the constitution of Nepal and only 7.5% of respondents were known, and 37.3% were heard only about the constitutional provision.

Age-wise, the respondents of older age groups were higher percentage in unknown and respondents of younger groups were higher percentage in heard only about the constitutional provision. Similarly, education level-wise, the respondents of lower education level were higher percentage in unknown and respondents from higher education level were found higher percentage in heard only and known about the constitutional provision of the fundamental rights of health.

The Chi-Square (χ^2) test shows that there was a significant association ($\chi^2= 94.312$, $df = 10$ and $p = .000$, which is less than .05) found between the respondents of different *age-wise* groups in their knowledge and awareness on health as a fundamental right on the constitution of Nepal. Similarly, there was a significant association ($\chi^2= 107.126$, $df = 10$ and $p = .000$, which is less than .05) found between the respondents of different *education level-wise* groups in their knowledge and awareness on health as a fundamental right on the constitution of Nepal.

The occupation and family type-wise distribution of knowledge towards fundamental rights of health and health care services is presented in table 7.92.

Table 7.92: Knowledge towards Fundamental Right of Health of Constitution by Occupation and Family Type

Occupation		Response			Total	Pearson Chi-Square
		Known	Heard only	Unknown		
Agriculture	Count	24	117	197	338	Asymp. Sig. (2-sided) .000
	% within Occupation	7.1	34.6	58.3	100	
Job/ service in Nepal	Count	8	15	5	28	
	% within Occupation	28.6	53.6	17.9	100	
Construction/ Maintenance works	Count	2	12	6	20	
	% within Occupation	10.0	60.0	30.0	100	
Business	Count	2	11	20	33	
	% within Occupation	6.1	33.3	60.6	100	
Foreign Employment	Count	3	20	9	32	
	% within Occupation	9.4	62.5	28.1	100	
Job in India	Count	1	9	13	23	
	% within Occupation	4.3	39.1	56.5	100	
Housewife	Count	3	19	23	45	
	% within Occupation	6.7	42.2	51.1	100	
Ex-Army/ Pensioner/ Army in India or UK	Count	3	30	74	107	
	% within Occupation	2.8	28.0	69.2	100	
Others	Count	2	4	4	10	
	% within Occupation	20.0	40.0	40.0	100	

Total	Count	48	237	351	636	
	% within Occupation	7.5	37.3	55.2	100	
Types of Family						
Unitary	Count	13	114	151	278	Asymp. Sig. (2- sided) .026
	% within Types of Family	4.7	41.0	54.3	100	
Joint	Count	35	123	200	358	
	% within Types of Family	9.8	34.4	55.9	100	
Total	Count	48	237	351	636	
	% within Types of Family	7.5	37.3	55.2	100	

Source: Field Survey, 2015.

The table 7.92 shows that respondents of occupation having ex-army/pensioner or army in India/UK, (69.2%), business (60.6%), agriculture (58.3%) were higher percentage in unknown and foreign employment (62.5%), construction/maintenance works (60%), jobs/service in Nepal (53.6%) were in higher in heard only about the constitutional provision regarding the fundamental right of health. Similarly, respondents of a joint family were found higher percentage in unknown about the constitutional provision regarding fundamental rights of health.

The Chi-Square (χ^2) test shows that there was a significant association ($\chi^2= 55.010$, $df = 16$ and $p = .000$, which is less than .05) found between the respondents of different *occupation*-wise groups in their knowledge and awareness on health as a fundamental right on the constitution of Nepal. Similarly, there was a significant association ($\chi^2= 7.318$, $df = 2$ and $p = .026$, which is less than .05) found between the respondents of different *family type*-wise groups in their knowledge and awareness on health as a fundamental right on the constitution of Nepal.

The marital status and location (VDC) wise distribution of knowledge and association towards fundamental rights of health and health care services is presented in table 7.93:

Table 7.93: Knowledge towards Fundamental Right of Health of Constitution by Marital Status and VDC

Marital Status		Response			Total	Pearson Chi-Square
		Known	Heard only	Unknown		
Married	Count	40	202	280	522	Asymp. Sig. (2- sided) .000
	% within Marital Status	7.7	38.7	53.6	100	
Unmarried	Count	5	8	2	15	
	% within Marital Status	33.3	53.3	13.3	100	
Single (Widow/Widower)	Count	3	26	69	98	
	% within Marital Status	3.1	26.5	70.4	100	
Divorced	Count	0	1	0	1	
	% within Marital Status	0.0	100	0.0	100	
Total	Count	48	237	351	636	
	% within Marital Status	7.5	37.3	55.2	100	

VDC						
Alamdevi	Count	8	28	51	87	Asymp. Sig. (2- sided) .000
	% within VDC	9.2	32.2	58.6	100	
Birgha	Count	15	30	19	64	
	% within VDC	23.4	46.9	29.7	100	
ChandiBhanj yna	Count	4	11	65	80	
	% within VDC	5.0	13.8	81.3	100	
Jagatradevi	Count	4	72	46	122	
	% within VDC	3.3	59.0	37.7	100	
Malungga	Count	1	10	16	27	
	% within VDC	3.7	37.0	59.3	100	
Nibuwa Kharka	Count	2	25	30	57	
	% within VDC	3.5	43.9	52.6	100	
Pelakot	Count	0	19	35	54	
	% within VDC	0.0	35.2	64.8	100	
Pindikhola	Count	3	13	21	37	
	% within VDC	8.1	35.1	56.8	100	
Shree Krishna Gandaki	Count	11	29	68	108	
	% within VDC	10.2	26.9	63.0	100	
Total	Count	48	237	351	636	
	% within VDC	7.5	37.3	55.2	100	

Source: Field Survey, 2015.

The table 7.93 shows that, marital status-wise respondents of single (widow/widower) (70.4%), married (53.6%) were higher percentage in unknown. VDC-wise respondents of Chandibhanjyang VDC (81.3%), Pelakot VDC (64.8%), Shree Krishna Gandaki VDC (63%) were higher percentage in unknown about the constitutional provision regarding the fundamental rights of health.

The Chi-Square (χ^2) test shows that there was a significant association ($\chi^2= 30.980$, $df = 6$ and $p = .000$, which is less than .05) found between the respondents of different *marital status* wise groups in their knowledge and awareness on health as a fundamental right on the constitution of Nepal. Similarly, there was a significant association ($\chi^2= 92.225$, $df = 16$ and $p = .000$, which is less than .05) found between the respondents of different *VDC* wise groups in their knowledge and awareness on health as a fundamental right on the constitution of Nepal.

CHAPTER EIGHT

ACHIEVING HEALTH AND WELLBEINGS: PAST AND PRESENT

This chapter deals with the quantitative finding of practices in health, illness and medications as well as health-seeking behaviours among the Magars for achieving health and wellbeing in a medical pluralistic setting of the study area. The health and wellbeing is the main issue of the every socio-cultural context. The socio-cultural backgrounds of the community or individual are playing role in achieving health and well beings.

8.1 Seeking of Health and Healings

Someone himself/herself or a family member falls into illness, healing support is required for that ill-person. So, they seek healing facilities from either traditional; indigenous local medication, alternative medicine services, or bio-medicines services. Here some findings of the practices of seeking health and healing from the field survey are discussed.

8.1.1 Situation Illness and Seeking for Healings

8.1.1.1 Situation of Illness

Illness is a social phenomenon and exists in every society. The inquiry of distribution of illness and health-seeking patterns shows the health-seeking practices and behaviours among the Magars. The distribution of illness in the surveyed household in the past one year is discussed here and the result is presented in table 8.1:

Table 8.1: Situation of Illness Distribution in Respondents Households

VDC	Having Illness		Having not illness		Total	
	Count	%	Count	%	Count	%
Alamdevi	58	66.7	29	33.3	87	100
Birgha	28	43.8	36	56.3	64	100
ChandiBhanjyang	78	97.5	2	2.5	80	100
Jagatradevi	68	55.7	54	44.3	122	100
Malungga	21	77.8	6	22.2	27	100
Nibuwakharka	44	77.2	13	22.8	57	100
Pelakot	38	70.4	16	29.6	54	100
Pindikhola	24	64.9	13	35.1	37	100
Shree Krishna Gandaki	77	71.3	31	28.7	108	100
Total	436	68.6	200	31.4	636	100
Types of Family						
Unitary	177	63.7	101	36.3	278	100
Joint	259	72.3	99	27.7	358	100
Total	436	68.6	200	31.4	636	100

Source: Field Survey, 2015

The table 8.1 shows that the majority (68.6%) of households of Magar society suffered from some kind of illness either respondent him/herself or his/her family members within one year during survey time and 31.4% of household did not fall into illness during that time. It shows that there always exist some kinds of illness in the community as a social phenomenon.

8.1.1.2 Seeking for Healing in Illness

The pattern of health-seeking for healing when somebody or family members falls into illness depends upon the availability of health care facilities, socio-economic condition of household, socio-cultural beliefs and traditions, nature and seriousness of the illness, and knowledge about the illness and healings. In the survey, 436 (68.6%) households were found falling into illness in the past one-year period. The health-seeking behaviours of respondents in the illness are discussed here.

The response of seeking healing in the local setting of the respondents is presented in table 8.2:

Table 8.2: Seeking Healing at First in Past one-year when Falling in Ill

VDC		Seeking Healing at First						Total	Pears on Chi-Square
		Shaman (Lama/W archBhar mi)	Local Govt. Health post/Govt. Health Institution	Medicine Shop/Private Clinic	Hospit al	Nothing one / Stay at home	Local Churc h		
Alamdevi	Count	26	4	20	4	1	2	57	Asym p. Sig. (2-sided) .000
	%	45.6	7.0	35.1	7.0	1.8	3.5	100	
Birgha	Count	3	4	9	12	0	0	28	
	%	10.7	14.3	32.1	42.9	0.0	0.0	100	
ChandiBh anjyna	Count	18	5	47	8	0	0	78	
	%	23.1	6.4	60.3	10.3	0.0	0.0	100	
Jagatra devi	Count	10	11	23	23	0	0	67	
	%	14.9	16.4	34.3	34.3	0.0	0.0	100	
Malungga	Count	2	7	8	4	0	0	21	
	%	9.5	33.3	38.1	19.0	0.0	0.0	100	
Nibuwa kharka	Count	8	4	16	16	0	0	44	
	%	18.2	9.1	36.4	36.4	0.0	0.0	100	
Pelakot	Count	4	0	19	15	0	0	38	
	%	10.5	0.0	50.0	39.5	0.0	0.0	100	
Pindikhola	Count	3	1	12	8	0	0	24	
	%	12.5	4.2	50.0	33.3	0.0	0.0	100	
Shree Krishna Gandaki	Count	34	2	36	7	0	0	79	
	%	43.0	2.5	45.6	8.9	0.0	0.0	100	
Total	Count	108	38	190	97	1	2	436	
	%	24.8	8.7	43.6	22.2	0.2	0.5	100	
Marital Status									
Married	Count	83	29	161	81	1	0	355	Asym p. Sig. (2-sided)
	%	23.4	8.2	45.4	22.8	0.3	0.0	100	
Unmarried	Count	1	1	6	1	0	1	10	
	%	10.0	10.0	60.0	10.0	0.0	10.0	100	

Single (Widow/ Widower)	Count	24	8	23	15	0	1	71	.001
	%	33.8	11.3	32.4	21.1	0.0	1.4	100	
Total	Count	108	38	190	97	1	2	436	
	%	24.8	8.7	43.6	22.2	0.2	0.5	100	
Religion									
Traditional or Animist	Count	19	9	37	16	1	0	82	Asym p. Sig. (2- sided) .000
	%	23.2	11.0	45.1	19.5	1.2	0.0	100	
Buddhist	Count	15	7	34	15	0	0	71	
	%	21.1	9.9	47.9	21.1	0.0	0.0	100	
Hindu	Count	67	15	106	57	0	0	245	
	%	27.3	6.1	43.3	23.3	0.0	0.0	100	
Christian	Count	0	0	2	2	0	2	6	
	%	0.0	0.0	33.3	33.3	0.0	33.3	100	
Atheism/N astik	Count	1	0	1	0	0	0	2	
	%	50.0	0.0	50.0	0.0	0.0	0.0	100	
Don't Know	Count	6	7	10	7	0	0	30	
	%	20.0	23.3	33.3	23.3	0.0	0.0	100	
Total	Count	108	38	190	97	1	2	436	
	%	24.8	8.7	43.6	22.2	0.2	0.5	100	

Source: Field Survey, 2015.

The table 8.2 shows that, a higher percentage of households (43.6%) visited medical shop/private clinics at first, and further 24.8% of households went to shaman (lama/ warcha bharmi). Likewise, 22.2% visited a hospital where only 8.7% of households visited local governmental health institutions and 0.5% of households visited the church at first when they fell into illness in past one year of the survey date.

The VDC-wise households from *Chandibhanjyang* (60.3%), *Pelakot* (50%), *Pindikhol*a (50%) were in higher percentage in visiting medicine shop and private clinics. The household from *Malungga* VDC (33.3%) had a higher percentage visiting governmental institutions than other VDCs due to some facilities of primary health center. Households from *Alamdevi* VDC (45.6%), *Shreekrishna Gandaki* (43%) households were higher percentage in visiting shaman. Marital status-wise, unmarried respondents' households (60%) were higher percentage in visiting a private clinic and single (widow/widower) (33.8%) were higher percentage in visiting shaman. Religion-wise, relatively Buddhist (47.9%), traditional or animist (45.1%) were higher percentage in visiting medicine shops/private clinics, Hindu (27.3%) were higher percentage in visiting shaman and Christian (33.3%) were visited churches more often in illness at first.

The Chi-Square (χ^2) test shows that there was a significant association ($\chi^2= 127.951$, $df = 40$ and $p = .000$, which is less than .05) found between the respondents of different VDCs wise groups in their practices on seeking healing in different health facilities (medical pluralistic settings) in first when falling illness in past one year of the survey. Similarly, there was a significant association ($\chi^2= 30.945$, $df = 10$ and $p = .001$, which is less than .05) found between the respondents of different marital status groups in their practices on seeking healing in different health facilities (medical pluralistic settings) in first when falling illness

in past one year of the survey. And, there was a significant association ($\chi^2 = 164.039$, $df = 25$ and $p = .00$, which is less than $.05$) found between the respondents of different *religion*-wise groups in their practices on seeking healing in different health facilities (medical pluralistic settings) in the first when falling illness in past one year of the survey.

8.1.2 Patterns to Visiting Modern Medical (bio-medical) Facilities

8.1.2.1 Going Trends of Magars to Governmental Health Institutions

There was one primary health centre, two health posts and six sub-health posts in the studied nine VDCs. The pattern of visiting local governmental health institutions to achieve health and wellbeing among the Magars is discussed here. The result is presented in table 8.3:

Table 8.3: Frequency of Visiting Local Health Institution of Government from the Magars in Past Five Years

VDC		Visiting Trends to Governmental Health Institutions/Local Health Posts					Total	Pearson Chi-Square
		Once	2-3 times	4or more times	Haven't gone	Don't Know		
Alamdevi	Count	27	21	18	19	2	87	Asymp. Sig. (2-sided) .000
	%	31.0	24.1	20.7	21.8	2.3	100	
Birgha	Count	10	28	9	17	0	64	
	%	15.6	43.8	14.1	26.6	0.0	100	
ChandiBhanjyang	Count	18	37	6	19	0	80	
	%	22.5	46.3	7.5	23.8	0.0	100	
Jagatradevi	Count	15	56	13	36	2	122	
	%	12.3	45.9	10.7	29.5	1.6	100	
Malungga	Count	2	15	6	4	0	27	
	%	7.4	55.6	22.2	14.8	0.0	100	
Nibuwakharka	Count	4	19	7	27	0	57	
	%	7.0	33.3	12.3	47.4	0.0	100	
Pelakot	Count	4	5	0	45	0	54	
	%	7.4	9.3	0.0	83.3	0.0	100	
Pindikhola	Count	0	12	3	22	0	37	
	%	0.0	32.4	8.1	59.5	0.0	100	
Shree Krishna Gandaki	Count	2	17	13	69	7	108	
	%	1.9	15.7	12.0	63.9	6.5	100	
Total	Count	82	210	75	258	11	636	
	%	12.9	33.0	11.8	40.6	1.7	100	
Marrital Status								
Married	Count	61	175	60	216	10	522	Asymp. Sig. (2-sided) .025
	%	11.7	33.5	11.5	41.4	1.9	100	
Unmarried	Count	6	4	2	2	1	15	
	%	40.0	26.7	13.3	13.3	6.7	100	
Single (Widow/ Widower)	Count	14	31	13	40	0	98	
	%	14.3	31.6	13.3	40.8	0.0	100	
Divorced	Count	1	0	0	0	0	1	
	%	100.0	0.0	0.0	0.0	0.0	100	
Total	Count	82	210	75	258	11	636	
	%	12.9	33.0	11.8	40.6	1.7	100	

Source: Field Survey, 2015.

The table 8.3 shows that a higher percentage of households (40.6%) were found not going to local government health institutions in the last five years and the majority (once gone 12.9%, twice to thrice 33% and four or more times 11.8%; in total 57.7%) households visited local health institutions during that of the survey date. However, visiting frequency to governmental health institutions was found at a lower rate. Most of the key informants told that unavailability of sufficient medicine, irregularity of health workers staying in the health institutions and long distances were the causes of a low rate of going to governmental health institutions.

The VDC wise, respondent households of *Pelakot* (83.3%), *Shresskrishna Gandaki* (63.9%), *Pindikhola* (59.5%) were higher percentage in have not gone, *Malungga* (55.6%), *Chandibhanjyang* (46.3%), *Jagatradevi* (45.9%) were higher percentage in visiting 2-3 times of local health institution of government. Marital status-wise, married respondents (41.4%) and single (40.8%) were higher percentage in have not gone and unmarried respondents households (40%) were higher percentage in going once in local health institution of government when falling in illness.

The Chi-Square (χ^2) test shows that there was a significant association ($\chi^2= 188.187$, $df = 32$ and $p = .000$, which is less than .05) found between the respondents of different *VDCs* wise groups in their practices on visiting pattern of local governmental health institutions when falling in illness in past five years of the survey. Similarly, there was a significant association ($\chi^2= 23.315$, $df = 12$ and $p = .025$, which is less than .05) found between the respondents of different *marital status*-wise groups in their practices on visiting pattern of local governmental health institutions when falling in illness in past five years of the survey.

8.1.2.2 Trends of Consulting Private Health Institutions of Magars

In Nepal, the majority of health care services are covered by the private sector. The private businesses are as medicine shops and supply, drugs production, community health institutions, hospitals and teachings of medical education. Here, achieving health and wellbeing from the private health institution is discussed.

The VDC-wise achieving health and wellbeing from private sectors is presented in table 8.4:

Table 8.4: Frequency of Visiting Private Health Sectors for Healings within Past Five Years

VDC		Trends of Visiting Private Sector for Healing					Total	Pearson Chi-Square
		Once	2-3 times	Four or more times	Haven't gone	Don't Know		
Alamdevi	Count	4	29	50	2	2	87	Asymp. Sig. (2-sided) .000
	%	4.6	33.3	57.5	2.3	2.3	100	
Birgha	Count	8	22	12	20	2	64	
	%	12.5	34.4	18.8	31.3	3.1	100	
ChandiBhanjyna	Count	5	33	41	0	1	80	
	%	6.3	41.3	51.3	0.0	1.3	100	
Jagatradevi	Count	6	48	45	21	2	122	
	%	4.9	39.3	36.9	17.2	1.6	100	
Malungga	Count	0	17	7	3	0	27	
	%	0.0	63.0	25.9	11.1	0.0	100	
Nibuwakharka	Count	1	21	29	5	1	57	
	%	1.8	36.8	50.9	8.8	1.8	100	
Pelakot	Count	1	16	32	4	1	54	
	%	1.9	29.6	59.3	7.4	1.9	100	
Pindikholā	Count	0	19	14	4	0	37	
	%	0.0	51.4	37.8	10.8	0.0	100	
Shree Krishna Gandaki	Count	3	22	77	0	6	108	
	%	2.8	20.4	71.3	0.0	5.6	100	
Total	Count	28	227	307	59	15	636	
	%	4.4	35.7	48.3	9.3	2.4	100	
Marital Status								
Married	Count	22	184	254	51	11	522	Asymp. Sig. (2-sided) .004
	%	4.2	35.2	48.7	9.8	2.1	100	
Unmarried	Count	0	9	5	0	1	15	
	%	0.0	60.0	33.3	0.0	6.7	100	
Single (Widow/Widower)	Count	5	34	48	8	3	98	
	%	5.1	34.7	49.0	8.2	3.1	100	
Divorced	Count	1	0	0	0	0	1	
	%	100.0	0.0	0.0	0.0	0.0	100	
Total	Count	28	227	307	59	15	636	
	%	4.4	35.7	48.3	9.3	2.4	100	

Source: Field Survey, 2015.

The table 8.4 shows that the majority of respondent's households visited private sectors in the last five years. The 48.3% of households went four or more times, 35.7% households went twice to thrice and 4.4% of households went once in private health sectors in the last five years. Only 9.3% of households did not visit private sectors for treatment. VDC-wise, the households from *Shreekrishna Gandaki* (71.3%) were higher percentage in going private health sectors for healing and household from *Malungga* (63%) were in higher percentage in 2-3 times going to private health sectors for healing in the last five years. Marital status-wise, single (widow/widower) and married respondent's household had higher percentages for going four or more times in private sectors for health-seeking.

The Chi-Square (χ^2) test shows that there was a significant association ($\chi^2 = 137.185$, $df = 32$ and $p = .000$, which is less than .05) found between the respondents of different VDCs wise

groups in their practices on visiting pattern of private health institutions when falling in illness in past five years of the survey. Similarly, there was a significant association ($\chi^2=28.969$, $df = 12$ and $p = .004$, which is less than .05) found between the respondents of different *marital status* wise groups in their practices on visiting pattern of private health institutions when falling in illness in past five years of the survey date.

The income source of household wise distribution on the pattern of going to the private health sector for healing within the last five years of the study is presented in table 8.5:

Table 8.5: Frequency of Visiting Private Health Sector for Healings within Past Five Years by Income Source of Household

Income Source of Household		Trends of Visiting Private Sector for Healing					Total	Pearson Chi-Square
		Once	2-3 times	Four or more times	Haven't gone	Don't Know		
Agriculture	Count	6	31	29	7	2	75	Asymp. Sig. (2-sided) .040
	%	8.0	41.3	38.7	9.3	2.7	100	
Agriculture, labour or wage's works, Skill works	Count	3	13	11	6	2	35	
	%	8.6	37.1	31.4	17.1	5.7	100	
Agriculture, Private Job in India or equivalence	Count	0	24	37	5	2	68	
	%	0.0	35.3	54.4	7.4	2.9	100	
Agriculture, Business/ small Entrepreneurships	Count	3	8	14	2	1	28	
	%	10.7	28.6	50.0	7.1	3.6	100	
Agriculture, Service/ Jobs in other sector	Count	0	6	10	3	1	20	
	%	0.0	30.0	50.0	15.0	5.0	100	
Agriculture, teacher/Nepal Army/Police/Govt. Job/Pension	Count	0	27	20	7	1	55	
	%	0.0	49.1	36.4	12.7	1.8	100	
Other sources not including Agriculture (e.g. Job, foreign employment, Business etc)	Count	2	14	26	0	0	42	
	%	4.8	33.3	61.9	0.0	0.0	100	
Agriculture, Foreign employment (Gulf, Malaysia or equivalent)	Count	3	37	68	15	2	125	
	%	2.4	29.6	54.4	12.0	1.6	100	
Agriculture, Indian Army/police or Pension	Count	6	56	82	13	4	161	
	%	3.7	34.8	50.9	8.1	2.5	100	
Agriculture, Foreign Employment (Korea, Afghanistan, Iraq, Europe, America or equivalent)	Count	4	7	8	1	0	20	
	%	20.0	35.0	40.0	5.0	0.0	100	
Agriculture, British Army/Singapore Police or Pensioner	Count	1	4	2	0	0	7	
	%	14.3	57.1	28.6	0.0	0.0	100	
Total	Count	28	227	307	59	15	636	
	%	4.4	35.7	48.3	9.3	2.4	100	

Source: Field Survey, 2015.

The table 8.5 shows that, respondents having income source other than agriculture (61.9%) were higher percentage in visiting four or more times and the respondents having income source agriculture, British army/ Singapore police or pensioner were higher percentage in going 2-3 times to private health sectors for treatment in last five years.

The Chi-Square (χ^2) test shows that there was a significant association ($\chi^2= 56.946$, $df = 40$ and $p = .040$, which is less than .05) found between the respondents of different *income source of household* wise groups in their practices on visiting pattern of private health institutions when falling in illness in past five years of the survey date.

8.1.3 Trends for Consulting Shaman

The Shamans (*lāmā/wārchabharmi*) are also traditional healers. They have the knowledge about locally available medicinal herbs and shrubs, substances and their use and doses. They also deal with souls, evil spirits, witchcraft and cultural healings. Here, the pattern of consulting shaman by the respondents for health and well-being is discussed.

The pattern of consultation with shaman according to VDC-wise and sex-wise is presented in table 8.6:

Table. 8.6: Frequency of Consulting Shaman for Healings by Sex and VDC

VDC		Trends of Consulting Shaman					Total	Pearson Chi-Square
		Once	2-3 times	Four or more times	Haven't gone/Invited	Don't Know		
Alamdevi	Count	4	20	50	10	3	87	Asymp. Sig. (2-sided) .000
	%	4.6	23.0	57.5	11.5	3.4	100	
Birgha	Count	11	19	6	24	4	64	
	%	17.2	29.7	9.4	37.5	6.3	100	
ChandiBhanjyang	Count	4	68	4	3	1	80	
	%	5.0	85.0	5.0	3.8	1.3	100	
Jagatradevi	Count	1	66	32	22	1	122	
	%	0.8	54.1	26.2	18.0	0.8	100	
Malungga	Count	0	14	8	5	0	27	
	%	0.0	51.9	29.6	18.5	0.0	100	
Nibuwakharka	Count	0	33	21	3	0	57	
	%	0.0	57.9	36.8	5.3	0.0	100	
Pelakot	Count	2	18	22	10	2	54	
	%	3.7	33.3	40.7	18.5	3.7	100	
Pindikholā	Count	0	14	4	18	1	37	
	%	0.0	37.8	10.8	48.6	2.7	100	
Shree Krishna Gandaki	Count	7	27	47	21	6	108	
	%	6.5	25.0	43.5	19.4	5.6	100	
Total	Count	29	279	194	116	18	636	
	%	4.6	43.9	30.5	18.2	2.8	100	
Sex								
Female	Count	11	131	119	52	5	318	Asymp. Sig. (2-sided) .002
	%	3.5	41.2	37.4	16.4	1.6	100	
Male	Count	18	148	75	64	13	318	
	%	5.7	46.5	23.6	20.1	4.1	100	
Total	Count	29	279	194	116	18	636	
	%	4.6	43.9	30.5	18.2	2.8	100	

Source: Field Survey, 2015.

The table 8.6 shows that majority of respondents of households (four or more times 43.9%, two-three times 43.9%, once 4.6%; in total 78.9%) were consulting the shaman for treatment in falling illness himself/herself or family members but only 18.2% households did not consult with a shaman in last five years of the survey.

The VDC-wise respondent households from *Chandibhanjyang*, *Nibuwakharka*, *Alamdevi* were in higher percentage in consulting shaman and respondents from *Pinidikhola* (48.6%) were higher percentage in not consulting a shaman in the past five-year duration. Sex-wise, females were slightly higher percentage in consulting shaman in the past five-year duration.

The Chi-Square (χ^2) test shows that there was a significant association ($\chi^2= 211.659$, $df = 32$ and $p = .000$, which is less than .05) found between the respondents of different VDC wise groups in their practices on consulting with shaman when falling in illness in past five years of the survey. Similarly, there was a significant association ($\chi^2= 17.502$, $df = 4$ and $p = .002$, which is less than .05) found between the respondents of different sex-wise groups in their practices on consulting with shaman when falling in illness in the past five years of the survey.

The occupation and marital status wise distribution of pattern and associations on consultation with a shaman for healing is presented in table 8.7:

Table 8.7: Frequency of Consulting Shaman for Healings by Occupation and Marital Status

Occupation		Trends of Consulting Shaman					Total	Pearson Chi-Square
		Once	2-3 times	Four or more times	Haven't gone/Invited	Don't Know		
Agriculture	Count	16	149	112	51	10	338	Asymp. Sig. (2-sided) .017
	%	4.7	44.1	33.1	15.1	3.0	100	
Job/ service in Nepal	Count	1	10	9	5	3	28	
	%	3.6	35.7	32.1	17.9	10.7	100	
Construction/ Maintenance works	Count	2	8	2	6	2	20	
	%	10.0	40.0	10.0	30.0	10.0	100	
Business	Count	1	11	11	10	0	33	
	%	3.0	33.3	33.3	30.3	0.0	100	
Foreign Employment	Count	3	17	6	6	0	32	
	%	9.4	53.1	18.8	18.8	0.0	100	
Job in India	Count	1	12	3	4	3	23	
	%	4.3	52.2	13.0	17.4	13.0	100	
Housewife	Count	1	19	21	4	0	45	
	%	2.2	42.2	46.7	8.9	0.0	100	
Ex-Army/Pensioner/Army in India or UK	Count	4	46	28	29	0	107	
	%	3.7	43.0	26.2	27.1	0.0	100	
Others	Count	0	7	2	1	0	10	
	%	0.0	70.0	20.0	10.0	0.0	100	
Total	Count	29	279	194	116	18	636	
	%	4.6	43.9	30.5	18.2	2.8	100	

Marital Status								
Married	Count	24	223	163	98	14	522	Asymp. Sig. (2- sided) .017
	%	4.6	42.7	31.2	18.8	2.7	100	
Unmarried	Count	0	7	3	2	3	15	
	%	0.0	46.7	20.0	13.3	20.0	100	
Single (Widow/ Widower)	Count	5	49	28	15	1	98	
	%	5.1	50.0	28.6	15.3	1.0	100	
Divorced	Count	0	0	0	1	0	1	
	%	0.0	0.0	0.0	100	0.0	100	
Total	Count	29	279	194	116	18	636	
	%	4.6	43.9	30.5	18.2	2.8	100	

Source: Field Survey, 2015.

The table 8.7 shows that, the respondents' occupation-wise, housewives were higher in percentage in consulting shaman. Marital status-wise, the single respondents (widow/widower) were higher in percentage in consulting shaman when falling ill.

The Chi-Square (χ^2) test shows that there was a significant association ($\chi^2 = 58.359$, $df = 32$ and $p = .003$, which is less than .05) found between the respondents of different *occupation* wise groups in their practices on consulting with shaman when falling in illness in past five years of the survey. Similarly, there was a significant association ($\chi^2 = 24.548$, $df = 12$ and $p = .017$, which is less than .05) found between the respondents of different *marital status* wise groups in their practices on consulting with shaman when falling in illness in past five years of the survey.

The income source of household wise distribution and associations of practicing on consultation with a shaman for healing is presented in table 8.8

Table 8.8: Frequency of Consulting Shaman for Healings by Income Source of Household

Income Source of Household		Trends of Consulting Shaman					Total	Pearson Chi-Square
		Once	2-3 times	Four or more times	Haven't gone/Invited	Don't Know		
Agriculture	Count	9	30	21	12	3	75	Asymp. Sig. (2- sided) .006
	%	12	40.0	28.0	16.0	4.0	100	
Agriculture, labour or wage's works, Skill works	Count	3	17	4	8	3	35	
	%	8.6	48.6	11.4	22.9	8.6	100	
Agriculture, Private Job in India or equivalence	Count	3	29	23	9	4	68	
	%	4.4	42.6	33.8	13.2	5.9	100	
Agriculture, Business/ small Entrepreneurships	Count	0	14	7	7	0	28	
	%	0.0	50.0	25.0	25.0	0.0	100	
Agriculture, Service/ Jobs in other sector	Count	0	9	6	4	1	20	
	%	0.0	45.0	30.0	20.0	5.0	100	
Agriculture, teacher/Nepal Army/Police/Govt. Job/Pension	Count	3	28	11	13	0	55	
	%	5.5	50.9	20.0	23.6	0.0	100	
Other sources not including Agriculture (e.g. Job, foreign employment, Business etc)	Count	0	11	23	7	1	42	
	%	0.0	26.2	54.8	16.7	2.4	100	
Agriculture, Foreign	Count	3	47	52	21	2	125	

employment (Gulf, Malaysia or equivalent)	%	2.4	37.6	41.6	16.8	1.6	100
Agriculture, Indian Army/police or Pension	Count	8	76	40	33	4	161
	%	5.0	47.2	24.8	20.5	2.5	100
Agriculture, Foreign Employment (Korea, Afghanistan, Iraq, Europe, America or equivalent)	Count	0	12	6	2	0	20
	%	0.0	60.0	30.0	10.0	0.0	100
Agriculture, British Army/Singapore Police or Pensioner	Count	0	6	1	0	0	7
	%	0.0	85.7	14.3	0.0	0.0	100
Total	Count	29	279	194	116	18	636
	%	4.6	43.9	30.5	18.2	2.8	100

Source: Field Survey, 2015.

The table 8.8 shows, respondents' households having agriculture as an income source with foreign employment (Korea, Afghanistan, Iraq, Europe, America or equivalent), Agriculture with foreign employment (Gulf, Malaysia or equivalent), Agriculture with Private Job in India or equivalence and only agriculture were higher percentage in consulting shaman for treatment in past five years duration.

The Chi-Square (χ^2) test shows that there was a significant association ($\chi^2 = 65.947$, $df = 40$ and $p = .006$, which is less than .05) found between the respondents of *different income source of household* wise groups in their practices on consulting with shaman when falling in illness in past five years of the survey.

8.1.4 Using Practice of *Jantar* (blessed charm) for Healing of Illness

In the study area, it is believed that wearing *Jantar* can protect from illness and misfortune (bad *grahadashā*) in the Magar community. The traditional *Jantar* is prepared by a shaman, astrologer (fortune teller), or priests. However, in the villages, imported wrist rings and other devices are also taking as a blessing charm (modern *Jantar*) to prevent hypertension, kidney diseases, diabetes, mental disorders, and so on. However, it is discussed about the traditional *Jantar*. The result of the using blessed charm (*Jantar*) is presented in table 8.9:

Table 8.9: Practices of Using Jantar (blessed charm) for Healings of Illness

Marital Status		Wearing Jantar		Total	Pearson Chi-Square
		Yes	No		
Married	Count	102	420	522	Asymp. Sig. (2-sided) .039
	% within Marital Status	19.5	80.5	100	
Unmarried	Count	7	8	15	
	% within Marital Status	46.7	53.3	100	
Single (Widow/Widower)	Count	15	83	98	
	% within Marital Status	15.3	84.7	100	
Divorced	Count	0	1	1	
	% within Marital Status	0.0	100.0	100	
Total	Count	124	512	636	

	% within Marital Status	19.5	80.5	100	
Language					
Magar	Count	111	494	605	Asymp. Sig. (2- sided) .001
	% within Language	18.3	81.7	100	
Nepali	Count	13	18	31	
	% within Language	41.9	58.1	100	
Total	Count	124	512	636	
	% within Language	19.5	80.5	100	

Source: Field Survey, 2015.

The table 8.9 shows that, majority of the respondents' households (80.5%) were not using *Jantar* (blessing charm) to prevent illness and cure illnesses, but 19.5% or 124 households were found using *Jantar* (blessing charm) to prevent illness and cure illness. Marital-wise, unmarried respondents' households were higher in percentage in using *Jantar*. Language-wise, the respondents with mother tongue Nepali were found to higher percentage in using *Jantar*.

The Chi-Square (χ^2) test shows that there was a significant association ($\chi^2= 8.394$, $df = 3$ and $p = .039$, which is less than .05) found between the respondents of different *marital status* wise groups in their practices on wearing *Jantar* (blessing charm) to prevent and cure illness. Similarly, there was a significant association ($\chi^2= 10.454$, $df = 1$ and $p = .001$, which is less than .05) found between the respondents of different *language-wise* groups in their practices on wearing *Jantar* (blessing charm) to prevent and cure illness.

8.1.4.1 Wearing of *Jantar* (blessed charm) by Relatives

In the survey, there was found 19.5% or 124 households found using *Jantar* (blessing charm) to prevent and cure illness and misfortune. The pattern of wearing *Jantar* by the family Member to achieve health and well beings is presented in table 8.10:

Table 8.10: Trends of Wearing *Jantar* by Family Members for Cure and Prevention of Illness by Education and Marital status

Education Level	Family Members Wearing <i>Jantar</i> to Cure and Prevent Illness															Pearson Chi-Square	
	Self	Son/ Daughter	Wife	Father/ Mother	Husband	Husband & Wife	Grand Daughter	Younger brother	Wife & Daughter	Self & Son/ Daughter	Elder & younger brother	Self and Mother/ Father	Daughter-in-law/ Buhari	Grand Daughter & Buhari	Total		
Illiterate	C	6	6	1	1	0	0	2	0	0	0	0	0	0	0	16	Asym p. Sig. (2-sided) .021
	%	37.5	37.5	6.3	6.3	0.0	0.0	12.5	0.0	0.0	0.0	0.0	0.0	0.0	0.0	100	
Literate/ Primary	C	22	16	3	4	1	0	2	0	0	2	0	0	1	1	52	
	%	42.3	30.8	5.8	7.7	1.9	0.0	3.8	0.0	0.0	3.8	0.0	0.0	1.9	1.9	100	
Lower Secondary	C	7	6	3	1	0	0	0	0	1	2	0	0	0	0	20	
	%	35	30	15	5.0	0.0	0.0	0.0	0.0	5.0	10.0	0.0	0.0	0.0	0.0	100	
Secondary	C	5	13	2	0	0	1	0	0	0	0	1	0	0	0	22	
	%	22.7	59.1	9.1	0.0	0.0	4.5	0.0	0.0	0.0	0.0	4.5	0.0	0.0	0.0	100	
Certificate Level/+2	C	2	1	4	1	0	0	0	1	0	0	0	0	0	0	9	
	%	22.2	11.1	44.4	11.1	0.0	0.0	0.0	11.1	0.0	0.0	0.0	0.0	0.0	0.0	100	
Bachelor & above	C	2	0	1	1	0	0	0	0	0	0	0	1	0	0	5	
	%	40.0	0.0	20.0	20.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	20.0	0.0	0.0	100	
Total	C	44	42	14	8	1	1	4	1	1	4	1	1	1	1	124	
	%	35.5	33.9	11.3	6.5	0.8	0.8	3.2	0.8	0.8	3.2	0.8	0.8	0.8	0.8	100	
Marital Status																	
Married	C	38	36	12	8	1	1	2	0	1	2	0	0	1	0	102	Asym p. Sig. (2-sided) .001
	%	37.3	35.3	11.8	7.8	1.0	1.0	2.0	0.0	1.0	2.0	0.0	0.0	1.0	0.0	100	
Unmarried	C	1	1	1	0	0	0	0	1	0	0	1	1	0	0	6	
	%	16.7	16.7	16.7	0.0	0.0	0.0	0.0	16.7	0.0	0.0	16.7	16.7	0.0	0.0	100	
Single (Widow/ Widower)	C	5	5	1	0	0	0	2	0	0	2	0	0	0	1	16	
	%	31.3	31.3	6.3	0.0	0.0	0.0	12.5	0.0	0.0	12.5	0.0	0.0	0.0	6.3	100	
Total	C	44	42	14	8	1	1	4	1	1	4	1	1	1	1	124	
	%	35.5	33.9	11.3	6.5	0.8	0.8	3.2	0.8	0.8	3.2	0.8	0.8	0.8	0.8	100.0	

Source: Field Survey, 2015.

The table 8.10 shows that, among the 124 respondents, 35.5% of respondents were found wearing *Jantar* by themselves and 33.9% or 42 households used *Jantar* by their son/daughter and 11.3% or 14 households *Jantars* were used by spouses to cure or prevent of illness and misfortune. In total 124 households, education-wise, 52 (41.94%) respondents having literate/primary level and marital status-wise, 102 (82.26%) respondents of married groups were using *Jantar* in their households.

The Chi-Square (χ^2) test shows that there was a significant association ($\chi^2= 90.144$, $df = 65$ and $p = .021$, which is less than .05) found between the respondents of *different education level*-wise groups in their practices on wearing *Jantar* (blessing charm) by family members to

prevent and cure illness. Similarly, there was a significant association ($\chi^2= 80.191$, $df = 26$ and $p = .000$, which is less than .05) found between the respondents of different *marital status* wise groups in their practices on wearing *Jantar* (blessing charm) by family members to prevent and cure illness.

8.1.5 Reasons of Wearing *Jantar*

The socio-cultural background of using *Jantar* in Magars society is connected with achieving health and wellbeing. So, here respondent's view on reasons for wearing *Jantar* is discussed. The marital status and religion-wise distribution of perceptions on the reason of wearing *Jantar* among the Magars are presented in table 8.11:

Table 8.11: Reason in Wearing of Jantar by Marital Status and Religion

Marital Status		Reason of Wearing Practice of Jantar								Total	Pearson Chi-Square	
		Wishing to good health	To strengthening fortune	Satisfaction of mind	Being Traditional Custom	Superstition belief	To secure from spirit/ evil-eye/ witch	Don't allow by my religion	Don't Know			
Married	Count	176	115	132	37	26	13	1	22	522	Asym p. Sig. (2-sided) .003	
	%	33.7	22.0	25.3	7.1	5.0	2.5	0.2	4.2	100		
Unmarried	Count	2	5	5	2	0	0	1	0	15		
	%	13.3	33.3	33.3	13.3	0.0	0.0	6.7	0.0	100		
Single (Widow/ Widower)	Count	33	22	24	8	3	5	1	2	98		
	%	33.7	22.4	24.5	8.2	3.1	5.1	1.0	2.0	100		
Divorced	Count	0	0	0	0	1	0	0	0	1		
	%	0.0	0.0	0.0	0.0	100	0.0	0.0	0.0	100		
Total	Count	211	142	161	47	30	18	3	24	636		
	%	33.2	22.3	25.3	7.4	4.7	2.8	0.5	3.8	100		
Religion												
Traditional or Animist	Count	36	28	39	21	10	8	0	4	146		Asym p. Sig. (2-sided) .000
	%	24.7	19.2	26.7	14.4	6.8%	5.5	0.0	2.7	100		
Buddhist	Count	34	25	18	4	1	0	0	3	85		
	%	40.0	29.4	21.2	4.7	1.2	0.0	0.0	3.5	100		
Hindu	Count	127	83	86	19	17	10	0	14	356		
	%	35.7	23.3	24.2	5.3	4.8	2.8	0.0	3.9	100		
Christian	Count	3	0	1	0	0	0	3	0	7		
	%	42.9	0.0	14.3	0.0	0.0	0.0	42.9	0.0	100		
Atheism/ Nastik	Count	0	0	1	1	0	0	0	0	2		
	%	0.0	0.0	50.0	50.0	0.0	0.0	0.0	0.0	100		
Don't Know	Count	11	6	16	2	2	0	0	3	40		
	%	27.5	15.0	40.0	5.0	5.0	0.0	0.0	7.5	100		
Total	Count	211	142	161	47	30	18	3	24	636		
	%	33.2	22.3	25.3	7.4	4.7	2.8	0.5	3.8	100		

Source: Field Survey, 2015.

The table 8.11 shows that, majority of the respondents (Wishing to good health 33.2%, to strengthening fortune 22.3%, to secure from spirit/ evil-eye/ witch 2.8%, satisfaction of mind

25.3%) were related with illness and prevention of illness. Similarly, 7.4% of respondents told as being traditional custom, 0.5% of respondents of the Christian religion replied as don't allow by my religion and 4.7% respondents opined just superstition and 3.8% respondents were unknown about the reason of wearing *Jantar* (blessed charm).

The Chi-Square (χ^2) test shows that there was a significant association ($\chi^2 = 43.228$, $df = 21$ and $p = .003$, which is less than .05) found between the respondents of different *marital status* wise groups in their perception on causation of wearing *Jantar* practice among the Magars. Similarly, there was a significant association ($\chi^2 = 318.703$, $df = 35$ and $p = .000$, which is less than .05) found between the respondents of different *religion*-wise groups in their perception on causation of wearing *Jantar* practice among the Magars.

8.2 Transferring Indigenous Knowledge to Offspring

Local peoples have their own indigenous knowledge, skills, technologies based on the local environment (physical and social both) about the way of life, survival, healing and health, and other aspects. In contrast, the indigenous knowledge, skills and technology, indigenous worldviews and philosophy of Magars are going to disappear. Here, teaching practices to offspring about indigenous knowledge of medicinal herbs and shrubs, medicinal substances and technologies are discussed. The age and sex-wise distribution and associations of practical behaviours of teaching IKS to their offspring are presented in table 8.12:

Table 8.12: Teaching Practice of Indigenous Knowledge to Offspring by Age and Sex

Age		Responses			Total	Pearson Chi-Square
		Sufficiently taught	A little bit taught	Haven't taught		
Under 25	Count	0	17	23	40	Asymp. Sig. (2-sided) .000
	%	0.0	42.5	57.5	100	
26 - 35	Count	2	54	73	129	
	%	1.6	41.9	56.6	100	
36 - 45	Count	2	72	71	145	
	%	1.4	49.7	49.0	100	
46 - 55	Count	10	68	52	130	
	%	7.7	52.3	40.0	100	
56 - 65	Count	5	66	40	111	
	%	4.5	59.5	36.0	100	
66 & above	Count	12	42	27	81	
	%	14.8	51.9	33.3	100	
Total	Count	31	319	286	636	
	%	4.9	50.2	45.0	100	
Sex						
Female	Count	10	171	137	318	Asymp. Sig. (2-sided) .048
	%	3.1	53.8	43.1	100	
Male	Count	21	148	149	318	
	%	6.6	46.5	46.9	100	
Total	Count	31	319	286	636	
	%	4.9	50.2	45.0	100	

Source: Field Survey, 2015.

The table 8.12 shows that, a higher percentage of respondents (50.2%) found getting a little bit of knowledge from their parents or grandparents, and 4.9% of respondents got sufficient knowledge from their parents or grandparents. However, 45% of respondents did not get any knowledge from their parents and grandparents about the IKS related to health and healings. Age-wise, the respondents of older age groups were in a higher percentage who got teaching whereas younger age groups were higher percentage in not getting teaching from their parents and grandparents. This fact indicates that the indigenous knowledge on Magar is going to disappear by their practice. Sex-wise, female respondents were in a higher

percentage in getting education from the parents and grandparents about the IKS to health and healings.

The Chi-Square (χ^2) test shows that there was a significant association ($\chi^2= 42.312$, $df = 10$ and $p = .000$, which is less than .05) found between the respondents of different age-wise groups in their practices on the teaching of indigenous knowledge to their offspring. Similarly, there was a significant association ($\chi^2= 6.065$, $df = 2$ and $p = .048$, which is less than .05) found between the respondents of different sex-wise groups in their practices on the teaching of IKS to their offspring.

The occupation wise distribution and association of practical behaviours of teaching IKS to their offspring is presented in table 8.13:

Table 8.13: Teaching Practice of Indigenous Knowledge to Offspring by Occupation

Occupation		Responses			Total	Pearson Chi-Square
		Sufficiently taught	A little bit taught	Haven't taught		
Agriculture	Count	17	175	146	338	Asymp. Sig. (2-sided) .038
	%	5.0	51.8	43.2	100	
Job/ service in Nepal	Count	2	15	11	28	
	%	7.1	53.6	39.3	100	
Construction/ Maintenance works	Count	1	10	9	20	
	%	5.0	50.0	45.0	100	
Business	Count	0	14	19	33	
	%	0.0	42.4	57.6	100	
Foreign Employment	Count	0	13	19	32	
	%	0.0	40.6	59.4	100	
Job in India	Count	0	5	18	23	
	%	0.0	21.7	78.3	100	
Housewife	Count	1	21	23	45	
	%	2.2	46.7	51.1	100	
Ex-Army/Pensioner/ Army in India or UK	Count	9	62	36	107	
	%	8.4	57.9	33.6	100	
Others	Count	1	4	5	10	
	%	10.0	40.0	50.0	100	
Total	Count	31	319	286	636	
	%	4.9	50.2	45.0	100	

Source: Field Survey, 2015.

The table 8.13 shows that, occupation-wise, the respondents having ex-army/ pensioner/ army in India or UK, job/service in Nepal and agriculture occupation had a higher percentage in receiving teaching about the indigenous knowledge about health and healings.

The Chi-Square (χ^2) test shows that there was a significant association ($\chi^2= 27.298$, $df = 16$ and $p = .038$, which is less than .05) found between the respondents of different occupation-wise groups in their practices on the teaching of IKS to their offspring.

The VDC wise distribution of practical behaviours of teaching IKS to their offspring is presented in table 8.14:

Table 8.14: Teaching Practice of Indigenous Knowledge to Offspring by VDC

VDC		Response			Total	Pearson Chi-Square
		Sufficiently taught	A little bit taught	Haven't taught		
Alamdevi	Count	5	55	27	87	Asymp. Sig. (2-sided) .000
	%	5.7	63.2	31.0	100	
Birgha	Count	2	48	14	64	
	%	3.1	75.0	21.9	100	
ChandiBhanjyang	Count	4	47	29	80	
	%	5.0	58.8	36.3	100	
Jagatradevi	Count	4	65	53	122	
	%	3.3	53.3	43.4	100	
Malungga	Count	4	10	13	27	
	%	14.8	37.0	48.1	100	
Nibuwakharka	Count	7	22	28	57	
	%	12.3	38.6	49.1	100	
Pelakot	Count	3	20	31	54	
	%	5.6	37.0	57.4	100	
Pindikholā	Count	1	25	11	37	
	%	2.7	67.6	29.7	100	
Shree Krishna Gandaki	Count	1	27	80	108	
	%	0.9	25.0	74.1	100	
Total	Count	31	319	286	636	
	%	4.9	50.2	45.0	100	

Source: Field Survey, 2015.

The table 8.14 shows that, the respondents from Birgha VDC, Pindikholā VDC, and Alamdevi VDC were in a higher percentage in getting indigenous knowledge from their parents or grandparents about the health and healings.

The Chi-Square (χ^2) test shows that there was a significant association ($\chi^2 = 86.496$, $df = 16$ and $p = .000$, which is less than .05) found between the respondents of different VDC wise groups in their practices on the teaching of IKS to their offspring.

8.3 Medicine Storing Practice at Home

Self-medication and storing of allopathic medicine (bio-medicine) at home is also practiced in society to achieve health and wellbeing. However, ethically, experts are needed to prescribe any medicine for a sick person. Allopathic medicine can give a result in adverse effects, allergies and sometimes it can be a life-threatening condition. On the other hand, in Magar villages, medicinal plants, herbs and shrubs and traditional medicines are collected as per their IKS and stored. In fact, the quality of traditional medicines is always unknown because it is not well-documented about the uses, doses and durations. However, both traditional and modern (allopathic) medicines are stored at home and self-medication is practiced. This situation is also created due to remoteness, geographical difficulties, unavailability of medical experts in local settings, and difficulty in consultation with doctors at right time.

Here, the practices of storing medicines both traditional (indigenous) and allopathic, and self-medication among the Magars are discussed based on the field survey.

8.3.1 Practice of Storing Medicinal Herbs & Shrubs and Traditional Medicines

In Magar villages, people also use medicinal plants, herbs & shrubs and other medicinal substances to achieve health, healings and wellbeing. These indigenous practices are based on their own indigenous knowledge and skill. The Magars also have indigenous knowledge and skills (IKS) about the medicinal plant, herbs and shrubs, other medicinal substances and their uses, nomenclature of illness and healings on their settlement and their existing ecological environment (see Annex-IX).

Magar (October 2009) stated about the Magar's indigenous knowledge towards the local medicinal plants, collection of medicinal plants, refining, storing and their uses including the role of women in collection, refining and storing of traditional medicines. Similarly, Hitchcock (1966), Shepherd (1982) indicated using local herbs and shrubs in the Magar villages. So, the literature also shows that the Magars have IKS in medicinal herbs and shrubs, plants and substances to achieve health and well-being. The practices storing traditional medicines such as medicinal herb & shrubs, plants and substances for achieving health and well-being are discussed here. And, the analysis and the result is presented in table 8.15:

Table 8.15: The Practice of Storing Traditional Medicines at Home for Illness

VDC		Response					Total	Pearson Chi-Square
		Do store	Before done but not now	Go to find out when needed	Don't do store	Don't Know		
Alamdevi	Count	11	7	31	36	2	87	Asymp. Sig. (2-sided) .000
	%	12.6	8.0	35.6	41.4	2.3	100	
Birgha	Count	14	4	41	5	0	64	
	%	21.9	6.3	64.1	7.8	0.0	100	
ChandiBhanjyang	Count	10	2	37	27	4	80	
	%	12.5	2.5	46.3	33.8	5.0	100	
Jagatradevi	Count	19	13	68	20	2	122	
	%	15.6	10.7	55.7	16.4	1.6	100	
Malungga	Count	3	1	19	4	0	27	
	%	11.1	3.7	70.4	14.8	0.0	100	
Nibuwa kharka	Count	8	7	30	9	3	57	
	%	14.0	12.3	52.6	15.8	5.3	100	
Pelakot	Count	14	2	25	9	4	54	
	%	25.9	3.7	46.3	16.7	7.4	100	
Pindikholā	Count	12	5	15	4	1	37	
	%	32.4	13.5	40.5	10.8	2.7	100	
Shree Krishna Gandaki	Count	13	9	17	66	3	108	
	%	12.0	8.3	15.7	61.1	2.8	100	
Total	Count	104	50	283	180	19	636	
	%	16.4	7.9	44.5	28.3	3.0	100	
Religion								Asymp. Sig. (2-sided) .008
Traditional or Animist	Count	30	8	74	34	0	146	
	%	20.5	5.5	50.7	23.3	0.0	100	
Buddhist	Count	15	4	40	22	4	85	
	%	17.6	4.7	47.1	25.9	4.7	100	
Hindu	Count	52	28	149	114	13	356	
	%	14.6	7.9	41.9	32.0	3.7	100	
Christian	Count	0	1	3	2	1	7	
	%	0.0	14.3	42.9	28.6	14.3	100	
Atheism/Nastik	Count	0	0	0	2	0	2	
	%	0.0	0.0	0.0	100.0	0.0	100	
Don't Know	Count	7	9	17	6	1	40	
	%	17.5	22.5	42.5	15.0	2.5	100	
Total	Count	104	50	283	180	19	636	
	%	16.4	7.9	44.5	28.3	3.0	100	

Source: Field Survey, 2015.

The table 8.15 shows that, the majority of respondents' households do not store traditional medicines. Among them, 44.5% of respondents do not store but go to search when needed, 7.9% of households currently leaving their practices in storing traditional medicines and 28.3% did not store traditional medicines. Only 16.4% of households were doing their traditional practices in collecting and storing traditional medicines known by their ancestors. VDC-wise, the Magar households of Pidikhola (32.4%), Pelakot (25.9%) were higher in

percentage in collecting and conserving traditional medicines. Religion-wise, traditional/animist (20.5%) were in a higher percentage in storing traditional medicines.

The Chi-Square (χ^2) test shows that there was a significant association ($\chi^2 = 141.719$, $df = 32$ and $p = .000$, which is less than .05) found between the respondents of different *VDC* wise groups in their practices on storing traditional medicine in their home. Similarly, there was a significant association ($\chi^2 = 38.413$, $df = 20$ and $p = .008$, which is less than .05) found between the respondents of different *religion*-wise groups in their practices on storing traditional medicine in their home.

8.3.2 Practice of Storing Allopathic Drugs

Allopathic drugs (medicines) can produce adverse effects; even sometimes it may be a life-threatening condition in case of using wrongly or from the wrong person's advice. Therefore, storing allopathic medicine and self-medication are not supposed as good in bio-medicine. The practices of storing allopathic medicines at home for self-medication among the Magars are discussed here. The sex and types of family-wise practices in storing allopathic medicine in their own house for self-medication are presented in table 8.16:

Table 8.16: Practice in Storing Allopathic Medicine at Home by Sex and Family type

Sex		Response					Total	Pearson Chi-Square	
		Frequently do store	Sometimes do store	Go to buy when needs	Don't do store	Don't Know			
Female	Count	85	80	106	47	0	318	Asymp. Sig. (2-sided) .019	
	%	26.7	25.2	33.3	14.8	0.0	100		
Male	Count	81	97	86	46	8	318		
	%	25.5	30.5	27.0	14.5	2.5	100		
Total	Count	166	177	192	93	8	636		
	%	26.1	27.8	30.2	14.6	1.3	100		
Types of Family									
Unitary	Count	62	71	87	55	3	278		Asymp. Sig. (2-sided) .011
	%	22.3	25.5	31.3	19.8	1.1	100		
Joint	Count	104	106	105	38	5	358		
	%	29.1	29.6	29.3	10.6	1.4	100		
Total	Count	166	177	192	93	8	636		
	%	26.1	27.8	30.2	14.6	1.3	100		

Source: Field Survey, 2015.

The table 8.16 shows that, the majority of respondents (frequently do store 26.1%, sometimes do store 27.8%) were found storing allopathic medicine for self-medication. Further, 30.2% of households go to buy when needed and only 14.6% of households do not do a store of allopathic drugs for self-medication. Sex-wise, the respondents from male groups and types

of family-wise, joint families were found higher percentage in storing medicine at home for self-medication.

The Chi-Square (χ^2) test shows that there was a significant association ($\chi^2= 11.823$, $df = 4$ and $p = .019$, which is less than .05) found between the respondents of different *sex-wise* groups in their practices on storing allopathic medicine in their home. Similarly, there was a significant association ($\chi^2= 12.985$, $df = 4$ and $p = .011$, which is less than .05) found between the respondents of different *types of family-wise* groups in their practices on storing allopathic medicine in their home.

The occupation wise practice and associations in storing allopathic medicine in their own house for self-medication is presented in table 8.17:

Table 8.17: Practice in Storing Allopathic Medicine at Home by Occupation

Occupation		Response					Total	Pearson Chi-Square
		Frequently do store	Sometimes do store	Go to buy when needs	Don't do store	Don't Know		
Agriculture	Count	66	98	122	49	3	338	Asymp. Sig. (2-sided) .000
	%	19.5	29.0	36.1	14.5	0.9	100	
Job/ service in Nepal	Count	9	13	3	2	1	28	
	%	32.1	46.4	10.7	7.1	3.6	100	
Construction/ Maintenance works	Count	5	5	6	4	0	20	
	%	25.0	25.0	30.0	20.0	0.0	100	
Business	Count	7	5	15	6	0	33	
	%	21.2	15.2	45.5	18.2	0.0	100	
Foreign Employment	Count	6	6	11	7	2	32	
	%	18.8	18.8	34.4	21.9	6.3	100	
Job in India	Count	4	11	2	6	0	23	
	%	17.4	47.8	8.7	26.1	0.0	100	
House wife	Count	12	11	12	10	0	45	
	%	26.7	24.4	26.7	22.2	0.0	100	
Ex-Army/Pensioner/Army in India or UK	Count	53	26	18	8	2	107	
	%	49.5	24.3	16.8	7.5	1.9	100	
Others	Count	4	2	3	1	0	10	
	%	40.0	20.0	30.0	10.0	0.0	100	
Total	Count	166	177	192	93	8	636	
	%	26.1	27.8	30.2	14.6	1.3	100	

Source: Field Survey, 2015.

The table 8.17 shows that the respondents having the occupation of job/service in Nepal, ex-army/pensioner/ army in the UK or India were found higher in percentage in storing allopathic medicine at home for self-medication.

The Chi-Square (χ^2) test shows that there was a significant association ($\chi^2= 82.324$, $df=32$ and $p = .000$, which is less than .05) found between the respondents of different *occupation* wise groups in their practices on storing allopathic medicine in their home.

The income source of household wise practices and associations in storing allopathic medicine in their own house for self-medication is presented in table 8.18:

Table 8.18: Practice in Storing Allopathic Medicine at Home by Income Source of Household

Income Source of Household		Response					Total	Pearson Chi-Square
		Frequently do store	Sometimes do store	Go to buy when needs	Don't do store	Don't Know		
Agriculture	Count	12	20	29	13	1	75	Asymp . Sig. (2-sided) .001
	%	16.0	26.7	38.7	17.3	1.3	100	
Agriculture, labour or wage's works, Skill works	Count	5	7	16	7	0	35	
	%	14.3	20.0	45.7	20.0	0.0	100	
Agriculture, Private Job in India or equivalence	Count	9	26	16	17	0	68	
	%	13.2	38.2	23.5	25.0	0.0	100	
Agriculture, Business/ small Entrepreneurships	Count	10	5	9	4	0	28	
	%	35.7	17.9	32.1	14.3	0.0	100	
Agriculture, Service/ Jobs in other sectors	Count	7	7	3	3	0	20	
	%	35.0	35.0	15.0	15.0	0.0	100	
Agriculture, teacher/Nepal Army/Police/Govt. Job/Pension	Count	13	18	16	7	1	55	
	%	23.6	32.7	29.1	12.7	1.8	100	
Other sources not including Agriculture (e.g. Job, foreign employment, Business etc)	Count	14	8	12	8	0	42	
	%	33.3	19.0	28.6	19.0	0.0	100	
Agriculture, Foreign employment (Gulf, Malaysia or equivalent)	Count	20	37	46	19	3	125	
	%	16.0	29.6	36.8	15.2	2.4	100	
Agriculture, Indian Army/police or Pension	Count	65	41	42	10	3	161	
	%	40.4	25.5	26.1	6.2	1.9	100	
Agriculture, Foreign Employment (Korea, Afghanistan, Iraq, Europe, America or equivalent)	Count	8	6	3	3	0	20	
	%	40.0	30.0	15.0	15.0	0.0	100	
Agriculture, British Army/Singapore Police or Pensioner	Count	3	2	0	2	0	7	
	%	42.9	28.6	0.0	28.6	0.0	100	
Total	Count	166	177	192	93	8	636	
	%	26.1	27.8	30.2	14.6	1.3	100	

Source: Field survey, 2015.

The table 8.18 shows, the Chi-Square (χ^2) test shows that there was a significant association ($\chi^2= 72.082$, $df=40$ and $p = .001$, which is less than $.05$) found between the respondents of different *income source of household* wise groups in their practices on storing allopathic medicine in their home.

The VDC wise practices and associations in storing allopathic medicine in their own house for self-medication is presented in table 8.19:

Table 8.19: Practice in Storing Allopathic Medicine at Home by VDC settlement

VDC		Response					Total	Pearson Chi-Square
		Frequently do store	Sometimes do store	Go to buy when needs	Don't do store	Don't Know		
Alamdevi	Count	34	22	23	8	0	87	Asymp. Sig. (2-sided) .000
	%	39.1	25.3	26.4	9.2	0.0	100	
Birgha	Count	4	11	44	5	0	64	
	%	6.3	17.2	68.8	7.8	0.0	100	
ChandiBhanjyna	Count	21	18	20	20	1	80	
	%	26.3	22.5	25.0	25.0	1.3	100	
Jagatradevi	Count	39	29	33	17	4	122	
	%	32.0	23.8	27.0	13.9	3.3	100	
Malungga	Count	7	7	6	6	1	27	
	%	25.9	25.9	22.2	22.2	3.7	100	
Nibuwakharka	Count	12	24	10	10	1	57	
	%	21.1	42.1	17.5	17.5	1.8	100	
Pelakot	Count	22	19	10	3	0	54	
	%	40.7	35.2	18.5	5.6	0.0	100	
Pindikholā	Count	15	11	6	5	0	37	
	%	40.5	29.7	16.2	13.5	0.0	100	
Shree Krishna Gandaki	Count	12	36	40	19	1	108	
	%	11.1	33.3	37.0	17.6	0.9	100	
Total	Count	166	177	192	93	8	636	
	%	26.1	27.8	30.2	14.6	1.3	100	

Source: Field Survey, 2015.

The table 8.19 shows the households from Pindikholā, Pelakot, and Alamdevi VDCs had higher percentage in storing allopathic medicines at home for self-medication. The far distance or remoteness to get medicine or reach medicine shop or health institution was also encouraged to store medicines at home.

The Chi-Square (χ^2) test shows that there was a significant association ($\chi^2= 111.420$, $df=32$ and $p = .000$, which is less than $.05$) found between the respondents of different VDC wise groups in their practices on storing allopathic medicine in their home.

8.4 Practices of Self Medication

8.4.1 Situation of Self-medication Practice

The storing of allopathic medicine at home for self-use is discussed above. The majority of respondents were storing medicines for some simple illnesses at home use. Self-medication practice is the use of medicines without a qualified and registered medical practitioner. Here, self-medicine practice is discussed. The analysis and result are presented in table 8.20:

Table 8.20: Practices of Self-medication among the Magars

VDC		Responses		Total	Pearson Chi-Square
		Yes	No		
Alamdevi	Count	61	25	86	Asymp. Sig. (2-sided) .000
	% within VDC	70.9	29.1	100	
Birgha	Count	18	46	64	
	% within VDC	28.1	71.9	100	
ChandiBhanjyna	Count	48	32	80	
	% within VDC	60.0	40.0	100	
Jagatradevi	Count	92	30	122	
	% within VDC	75.4	24.6	100	
Malungga	Count	14	13	27	
	% within VDC	51.9	48.1	100	
Nibuwakharka	Count	29	28	57	
	% within VDC	50.9	49.1	100	
Pelakot	Count	33	21	54	
	% within VDC	61.1	38.9	100	
Pindikhola	Count	28	9	37	
	% within VDC	75.7	24.3	100	
Shree Krishna Gandaki	Count	45	63	108	
	% within VDC	41.7	58.3	100	
Total	Count	368	267	635	
	% within VDC	58.0	42.0	100	
Religion					
Traditional or Animist	Count	106	40	146	Asymp. Sig. (2-sided) .000
	% within Religion	72.6	27.4	100	
Buddhist	Count	52	33	85	
	% within Religion	61.2	38.8	100	
Hindu	Count	185	170	355	
	% within Religion	52.1	47.9	100	
Christian	Count	1	6	7	
	% within Religion	14.3	85.7	100	
Atheism/Nastik	Count	2	0	2	
	% within Religion	100.0	0.0	100	
Don't Know	Count	22	18	40	
	% within Religion	55.0	45.0	100	
Total	Count	368	267	635	
	% within Religion	58.0	42.0	100	

Source: Field Survey, 2015.

The table 8.20 shows that the majority of respondents (58%) found practicing self-medication when falling into illness without consulting doctors or health workers. VDC-wise, Pindikhola

(75.7%), Jagatradevi (75.4%), Alamdevi (70.09%) were in higher percentage in self-medication practices. Religion-wise, relatively traditional or animists (72.6%) were higher in percentage in self-medication practices.

The Chi-Square (χ^2) test shows that there was a significant association ($\chi^2= 63.036$, $df = 8$ and $p = .000$, which is less than .05) found between the respondents of different VDC wise groups in their practices on self-medication when falling into illness at home. Similarly, there was a significant association ($\chi^2= 25.262$, $df = 5$ and $p = .000$, which is less than .05) found between the respondents of different religion-wise groups in their practices on self-medication when falling into illness at home.

8.4.2 Nature of Drugs Using in Self-medication

Among the medicine storing respondents 368 (58%); the pattern of self-medication and nature of medicines they used is discussed here. The sex and marital status-wise distribution and association with the practices of nature or types of drugs in using self-medication are presented in table 8.21:

Table 8.21: Practice of Types of Drugs in Using Self-medication by Sex and Marital status

Sex		Responses				Total	Pearson Chi-Square	
		Over the counter drugs	Drug-related with common illness	Remainder drugs of patient for similar illness	Drugs which have little bit knowledge			
Female	Count	38	77	36	33	184	Asymp. Sig. (2-sided) .033	
	%	20.7	41.8	19.6	17.9	100		
Male	Count	20	90	30	44	184		
	%	10.9	48.9	16.3	23.9	100		
Total	Count	58	167	66	77	368		
	%	15.8	45.4	17.9	20.9	100		
Marital Status								
Married	Count	43	142	50	58	293		Asymp. Sig. (2-sided) .013
	%	14.7	48.5	17.1	19.8	100		
Unmarried	Count	0	3	0	6	9		
	%	0.0	33.3	0.0	66.7	100		
Single (Widow/Widower)	Count	15	21	16	13	65		
	%	23.1	32.3	24.6	20.0	100		
Divorced	Count	0	1	0	0	1		
	%	0.0	100.0	0.0	0.0	100		
Total	Count	58	167	66	77	368		
	%	15.8	45.4	17.9	20.9	100		

Source: Field Survey, 2015.

The table 8.21 shows that a major portion of respondents (45.4%) used drug-related common illness, 20.9% of respondents used drugs which have little bit knowledge, 17.9% of respondents used remainder drugs of patients for similar illness and 15.8% were used over the counter medicine for self-medication. Sex-wise, male respondents were higher in percentage in using drugs related

with common illness (48.9%). Marital status-wise, the respondents from married (48.5%) were higher in percentage using drugs with common illness for self-medication.

The Chi-Square (χ^2) test shows that there was a significant association ($\chi^2= 8.715$, $df = 3$ and $p = .033$, which is less than .05) found between the respondents of different sex-wise groups in their practices on nature or type of drugs using for self-medication when falling into illness at home. Similarly, there was a significant association ($\chi^2= 20.958$, $df = 9$ and $p = .013$, which is less than .05) found between the respondents of different marital status wise groups in their practices on nature or type of drugs using for self-medication when falling into illness at home.

The VDC wise distribution of practice of nature or types of drugs in using self-medication is presented in table 8.22:

Table 8.22: Practice of Types of Drugs in using Self-medication by VDC Settlement

VDC		Response				Total	Pearson Chi-Square
		Over the counter drugs	Drug-related with common illness	Remainder drugs of patient for similar illness	Drugs which have little bit knowledge		
Alamdevi	Count	10	17	13	22	62	Asymp. Sig. (2-sided) .000
	%	16.1	27.4	21.0	35.5	100	
Birgha	Count	0	9	2	6	17	
	%	0.0	52.9	11.8	35.3	100	
ChandiBhanjyang	Count	2	23	19	5	49	
	%	4.1	46.9	38.8	10.2	100	
Jagatradevi	Count	27	29	7	29	92	
	%	29.3	31.5	7.6	31.5	100	
Malungga	Count	1	7	4	2	14	
	%	7.1	50.0	28.6	14.3	100	
Nibuwakharka	Count	2	18	4	5	29	
	%	6.9	62.1	13.8	17.2	100	
Pelakot	Count	5	21	5	1	32	
	%	15.6	65.6	15.6	3.1	100	
Pindikholā	Count	1	20	4	3	28	
	%	3.6	71.4	14.3	10.7	100	
Shree Krishna Gandaki	Count	10	23	8	4	45	
	%	22.2	51.1	17.8	8.9	100	
Total	Count	58	167	66	77	368	
	%	15.8	45.4	17.9	20.9	100	

Source: Field Survey, 2015.

The table 8.22 shows that VDC-wise respondents from the *Pidikholā* (71.4%), *Pelakot* (65.6%), *Nibuwakharka* (62.1%) were higher in percentage in drug-related with common drugs, *Alamdevi* (35%) had a higher percentage in drugs which have little bit knowledge for using self-medication.

The Chi-Square (χ^2) test shows that there was a significant association ($\chi^2= 86.334$, $df =24$ and $p = .000$, which is less than .05) found between the respondents of different VDC wise

groups in their practices on nature or type of drugs using for self-medication when falling into illness at home.

The occupation wise distribution and association with practice of nature (or types) of drugs in using self-medication is presented in table 8.23:

Table 8.23: Practice of Types of Drugs in using Self- medication by Occupation

Occupation		Responses				Total	Pearson Chi-Square
		Over the counter drugs	Drug-related with common illness	Remainder drugs of patient for similar illness	Drugs which have little bit knowledge		
Agriculture	Count	30	88	41	29	188	Asymp. Sig. (2-sided) .026
	%	16.0	46.8	21.8	15.4	100	
Job/ service in Nepal	Count	2	8	0	9	19	
	%	10.5	42.1	0.0	47.4	100	
Construction/ Maintenance works	Count	3	4	1	2	10	
	%	30.0	40.0	10.0	20.0	100	
Business	Count	3	4	4	6	17	
	%	17.6	23.5	23.5	35.3	100	
Foreign Employment	Count	1	14	3	2	20	
	%	5.0	70.0	15.0	10.0	100	
Job in India	Count	0	7	1	2	10	
	%	0.0	70.0	10.0	20.0	100	
House wife	Count	5	14	4	5	28	
	%	17.9	50.0	14.3	17.9	100	
Ex-Army/Pensioner/Army in India or UK	Count	14	23	12	21	70	
	%	20.0	32.9	17.1	30.0	100	
Others	Count	0	5	0	1	6	
	%	0.0	83.3	0.0	16.7	100	
Total	Count	58	167	66	77	368	
	%	15.8	45.4	17.9	20.9	100	

Source: Field Survey, 2015.

The table 8.23 shows that, respondents having occupation jobs/services in Nepal (47.4%), business (35.3%) were higher in percentage in drugs which have little bit knowledge, having occupations others occupation (83.3%), foreign employment (70%), job in India (70%), housewife (50%) accounted higher percentage in drug-related with common illness for self-medication.

The Chi-Square (χ^2) test shows that there was a significant association ($\chi^2= 39.182$, $df=24$ and $p = .026$, which is less than .05) found between the respondents of different occupation wise groups in their practices on nature or type of drugs using for self-medication when falling into illness at home.

The income source of household wise distribution and associations with the practice of nature or types of drugs in using self-medication is presented in table 8.24

Table 8.24: Practice of Types of Drugs in using Self-medication by Income Source of Household

Income Source of Household		Response				Total	Pearson Chi-Square
		Over the counter drugs	Drug-related with common illness	Remainder drugs of patient for similar illness	Drugs which have little bit knowledge		
Agriculture	Count	6	14	15	9	44	Asymp. Sig. (2-sided) .009
	%	13.6	31.8	34.1	20.5	100	
Agriculture, labour or wage's works, Skill works	Count	2	7	4	2	15	
	%	13.3	46.7	26.7	13.3	100	
Agriculture, Private Job in India or equivalence	Count	2	20	4	4	30	
	%	6.7	66.7	13.3	13.3	100	
Agriculture, Business/ small Entrepreneurships	Count	2	6	5	6	19	
	%	10.5	31.6	26.3	31.6	100	
Agriculture, Service/ Jobs in other sectors	Count	2	5	2	4	13	
	%	15.4	38.5	15.4	30.8	100	
Agriculture, teacher/Nepal Army/Police/Govt. Job/Pension	Count	9	20	1	9	39	
	%	23.1	51.3	2.6	23.1	100	
Other sources not including Agriculture (e.g. Job, foreign employment, Business etc)	Count	3	12	1	7	23	
	%	13.0	52.2	4.3	30.4	100	
Agriculture, Foreign employment (Gulf, Malaysia or equivalent)	Count	7	38	13	9	67	
	%	10.4	56.7	19.4	13.4	100	
Agriculture, Indian Army/police or Pension	Count	19	38	21	23	101	
	%	18.8	37.6	20.8	22.8	100	
Agriculture, Foreign Employment (Korea, Afghanistan, Iraq, Europe, America or equivalent)	Count	3	7	0	3	13	
	%	23.1	53.8	0.0	23.1	100	
Agriculture, British Army/Singapore Police or Pensioner	Count	3	0	0	1	4	
	%	75.0	0.0	0.0	25.0	100	
Total	Count	58	167	66	77	368	
	%	15.8	45.4	17.9	20.9	100	

Source: Field Survey, 2015.

The table 8.24 shows that, having income source of households as agriculture with Private job in India or equivalence (66.7%), agriculture, foreign employment (Gulf, Malaysia or equivalent) (56.7%) consisted higher percentage in drug-related with common illness and having income source of households as agriculture, business/ small entrepreneurships (31.6%) were higher in percentage in drugs which have little knowledge about the self-medication practice.

The Chi-Square (χ^2) test shows that there was a significant association ($\chi^2 = 51.434$, $df = 30$ and $p = .009$, which is less than .05) found between the respondents of different income source of household wise groups in their practices on nature or type of drugs using for self-medication when falling into illness at home.

8.5 Situation of Affording to Medication

In Nepal, the medication cost of treatment is very expensive and difficult to afford for lower-class people. Many people die due to unable to afford medication in Nepalese society. And, many people sink in indebt when one family member falls into illness. The health care system of Nepal is available both in the private and government sector. But it is big business and investments. It has been seen health inequalities from the perspective of the cost of medication on the surface of society. Here, how costly it was felt by the Magars in practically in the villages are discussed.

8.5.1 Affording to Modern (bio-medicine) Medicine

The capability and feeling of affording to modern medication among the Magars respondents are discussed here.

The occupation-wise response and association in capability and feeling of cost for affording to modern medicine are presented in table 8.25:

Table 8.25: Capability and Feeling of Cost to Afford Modern Health Care by Occupation

Occupation		Response					Total	Pearson Chi-Square
		Cheap/ Accessible	Affordable	Expensive	Very Expensive	Don't Know		
Agriculture	Count	5	81	122	117	13	338	Asymp. Sig. (2-sided) .000
	%	1.5	24.0	36.1	34.6	3.8	100	
Job/ service in Nepal	Count	0	8	12	8	0	28	
	%	0.0	28.6	42.9	28.6	0.0	100	
Construction/ Maintenance works	Count	1	1	8	10	0	20	
	%	5.0	5.0	40.0	50.0	0.0	100	
Business	Count	0	5	9	18	1	33	
	%	0.0	15.2	27.3	54.5	3.0	100	
Foreign Employment	Count	1	11	9	11	0	32	
	%	3.1	34.4	28.1	34.4	0.0	100	
Job in India	Count	0	1	11	11	0	23	
	%	0.0	4.3	47.8	47.8	0.0	100	
House wife	Count	3	16	13	13	0	45	
	%	6.7	35.6	28.9	28.9	0.0	100	
Ex-Army/ Pensioner/ Army in India or UK	Count	2	55	27	22	1	107	
	%	1.9	51.4	25.2	20.6	0.9	100	
Others	Count	0	2	6	2	0	10	
	%	0.0	20.0	60.0	20.0	0.0	100	
Total	Count	12	180	217	212	15	636	
	%	1.9	28.3	34.1	33.3	2.4	100	

Source: Field Survey, 2015.

The table 8.25 shows that the majority of respondents felt practically expensive (expensive 34.1% and very expensive 33.3%) to afford modern medicine. Only 28.3% of respondents

experienced practically modern medicines as affordable. Occupation-wise, the occupation having as ex-army/pensioner/army in India or the UK (51.4%), housewife (35.6%), foreign employment (34.4%), job/service in Nepal (28.6%) were higher in percentage in the capability of affordable of modern medical cares.

The Chi-Square (χ^2) test shows that there was a significant association ($\chi^2= 73.171$, $df =32$ and $p = .000$, which is less than .05) found between the respondents of different *occupation* wise groups in their affordable capacity on the cost of modern medication.

The marital status and religion-wise responses and associations in capability and feeling of cost for affording to modern medicine is presented in table 8.26:

Table 8.26: Capability and Feeling of Cost to Afford Modern Health Care by Marital Status and Religion

Marital Status		Response					Total	Pearson Chi-Square	
		Cheap/ Accessible	Affordable	Expensive	Very Expensive	Don't Know			
Married	Count	7	142	180	183	10	522	Asymp. Sig. (2-sided) .045	
	%	1.3	27.2	34.5	35.1	1.9	100		
Unmarried	Count	1	2	9	3	0	15		
	%	6.7	13.3	60.0	20.0	0.0	100		
Single (Widow/ Widower)	Count	4	35	28	26	5	98		
	%	4.1	35.7	28.6	26.5	5.1	100		
Divorced	Count	0	1	0	0	0	1		
	%	0.0	100.0	0.0	0.0	0.0	100		
Total	Count	12	180	217	212	15	636		
	%	1.9	28.3	34.1	33.3	2.4	100		
Religion									Asymp. Sig. (2-sided) .003
Traditional or Animist	Count	4	54	44	43	1	146		
	%	2.7	37.0	30.1	29.5	0.7	100		
Buddhist	Count	2	26	28	25	4	85		
	%	2.4	30.6	32.9	29.4	4.7	100		
Hindu	Count	3	79	132	134	8	356		
	%	0.8	22.2	37.1	37.6	2.2	100		
Christian	Count	0	2	3	2	0	7		
	%	0.0	28.6	42.9	28.6	0.0	100		
Atheism/ Nastik	Count	0	0	2	0	0	2		
	%	0.0	0.0	100.0	0.0	0.0	100		
Don't Know	Count	3	19	8	8	2	40		
	%	7.5	47.5	20.0	20.0	5.0	100		
Total	Count	12	180	217	212	15	636		
	%	1.9	28.3	34.1	33.3	2.4	100		

Source: Field Survey, 2015.

The table 8.26 shows, marital status-wise, the respondents of unmarried groups were higher in percentage in saying as expensive. Religion-wise, relatively respondents from Hindu, Buddhist, tradition or animist were higher percentage in telling expensive for modern medicine.

The Chi-Square (χ^2) test shows that there was a significant association ($\chi^2= 21.379$, $df = 12$ and $p = .045$, which is less than $.05$) found between the respondents of different *marital status* wise groups in their affordable capacity on the cost of modern medication. Similarly, there was a significant association ($\chi^2= 41.767$, $df = 20$ and $p = .003$, which is less than $.05$) found between the respondents of different *religion*-wise groups in their affordable capacity on the cost of modern medication.

The VDC-wise response in capability and feeling of cost for affording to modern medicine is presented in table 8.27:

Table 8.27: Capability and Feeling of Cost to Afford Modern Health Care by VDC

VDC		Response					Total	Pearson Chi-Square
		Cheap/ Accessible	Affordable	Expensive	Very Expensive	Don't Know		
Alamdevi	Count	3	11	48	23	2	87	Asymp. Sig. (2-sided) .000
	%	3.4	12.6	55.2	26.4	2.3	100	
Birgha	Count	0	10	37	16	1	64	
	%	0.0	15.6	57.8	25.0	1.6	100	
Chandi Bhanjyang	Count	0	18	33	26	3	80	
	%	0.0	22.5	41.3	32.5	3.8	100	
Jagatradevi	Count	2	69	22	26	3	122	
	%	1.6	56.6	18.0	21.3	2.5	100	
Malungga	Count	1	8	3	15	0	27	
	%	3.7	29.6	11.1	55.6	0.0	100	
Nibuwa kharka	Count	2	21	14	19	1	57	
	%	3.5	36.8	24.6	33.3	1.8	100	
Pelakot	Count	2	10	22	20	0	54	
	%	3.7	18.5	40.7	37.0	0.0	100	
Pindikholi	Count	0	16	12	8	1	37	
	%	0.0	43.2	32.4	21.6	2.7	100	
Shree Krishna Gandaki	Count	2	17	26	59	4	108	
	%	1.9	15.7	24.1	54.6	3.7	100	
Total	Count	12	180	217	212	15	636	
	%	1.9	28.3	34.1	33.3	2.4	100	

Source: Field Survey, 2015.

The table 8.27 shows that VDC-wise, the respondents of Birgh, Alamdevi, Shreekrishnaand Gandaki were higher in percentage in opining as expensive and respondents of Jagatradevi (56.6%) were higher percentage in telling affordable of modern medication.

The Chi-Square (χ^2) test shows that there was a significant association ($\chi^2= 139.493$, $df = 32$ and $p = .000$, which is less than $.05$) found between the respondents of different *VDC* wise groups in their affordable capacity on the cost of modern medication.

The income source of household wise response and association in capability and feeling of cost for affording to modern medicine is presented in table 8.28:

Table 8.28: Capability and Feeling of Cost to Afford Modern Health Care by Income Source of Household

Income Source of Household		Response					Total	Pearson Chi-Square
		Cheap/ Accessible	Affordable	Expensive	Very Expensive	Don't Know		
Agriculture	Count	1	9	36	25	4	75	Asymp. Sig. (2-sided) .009
	%	1.3	12.0	48.0	33.3	5.3	100	
Agriculture, labour or wage's works, Skill works	Count	1	3	11	20	0	35	
	%	2.9	8.6	31.4	57.1	0.0	100	
Agriculture, Private Job in India or equivalence	Count	1	12	24	29	2	68	
	%	1.5	17.6	35.3	42.6	2.9	100	
Agriculture, Business/ small Entrepreneurships	Count	0	8	8	11	1	28	
	%	0.0	28.6	28.6	39.3	3.6	100	
Agriculture, Service/ Jobs in other sector	Count	1	4	8	6	1	20	
	%	5.0	20.0	40.0	30.0	5.0	100	
Agriculture, teacher/Nepal Army/Police/Govt. Job/Pension	Count	2	19	20	14	0	55	
	%	3.6	34.5	36.4	25.5	0.0	100	
Other sources not including Agriculture (e.g. Job, foreign employment, Business etc)	Count	2	11	14	15	0	42	
	%	4.8	26.2	33.3	35.7	0.0	100	
Agriculture, Foreign employment (Gulf, Malaysia or equivalent)	Count	3	34	39	46	3	125	
	%	2.4	27.2	31.2	36.8	2.4	100	
Agriculture, Indian Army/police or Pension	Count	1	67	49	40	4	161	
	%	0.6	41.6	30.4	24.8	2.5	100	
Agriculture, Foreign Employment (Korea, Afghanistan, Iraq, Europe, America or equivalent)	Count	0	10	6	4	0	20	
	%	0.0	50.0	30.0	20.0	0.0	100	
Agriculture, British Army/Singapore Police or Pensioner	Count	0	3	2	2	0	7	
	%	0.0	42.9	28.6	28.6	0.0	100	
Total	Count	12	180	217	212	15	636	
	%	1.9	28.3	34.1	33.3	2.4	100	

Source: Field Survey, 2015.

The table 8.28 shows that, respondents having income source of households as Agriculture with Foreign Employment (Korea, Afghanistan, Iraq, Europe, America or equivalent) (50%), Agriculture, British Army/ Singapore Police or Pensioner (42.9%), Agriculture with Indian Army/ police or Pension (41.6%) were higher in percentage in affordable of modern

medication. And these income sources of household are considered as high-income source in the Magar villages.

The Chi-Square (χ^2) test shows that there was a significant association ($\chi^2= 64.245$, $df = 40$ and $p = .009$, which is less than .05) found between the respondents of different *income source of household* wise groups in their affordable capacity on the cost of modern medication.

8.5.2 Affording Cost Comparison between Traditional and Modern Medication

In Magar village, both traditional healings and modern medication are in practice. In traditional healing shamanism (*lāmā/ wārch bharmi*), worshipping shrine and local gods or ancestral god goddess, following astrologer or priest for *Grahadasā*, faith healing and dances (e.g. *Ghānto*), using medicinal plants, herbs shrubs and substances are found in the study area. However, bio-medicine is also expanding extensively at Magar villages. The result of comparison in affording cost practice in between traditional and modern medication is presented in table 8.29:

Table 8.29: Cheaper cost in between traditional and modern (bio-medicine) medication

VDC		Response				Total	Pearson Chi-Square
		Traditional Healing	Modern Medicine	Both are Expensive	Don't Know		
Alamdevi	Count	41	10	34	2	87	Asymp. Sig. (2-sided) .000
	%	47.1	11.5	39.1	2.3	100	
Birgha	Count	10	6	48	0	64	
	%	15.6	9.4	75.0	0.0	100	
ChandiBhanjyang	Count	40	3	33	4	80	
	%	50.0	3.8	41.3	5.0	100	
Jagatradevi	Count	54	32	29	7	122	
	%	44.3	26.2	23.8	5.7	100	
Malungga	Count	14	3	9	1	27	
	%	51.9	11.1	33.3	3.7	100	
Nibuwakharka	Count	30	12	12	3	57	
	%	52.6	21.1	21.1	5.3	100	
Pelakot	Count	27	10	16	1	54	
	%	50.0	18.5	29.6	1.9	100	
Pindikholā	Count	17	4	9	7	37	
	%	45.9	10.8	24.3	18.9	100	
Shree Krishna Gandaki	Count	38	32	37	1	108	
	%	35.2	29.6	34.3	0.9	100	
Total	Count	271	112	227	26	636	
	%	42.6	17.6	35.7	4.1	100	

Source: Field survey, 2015.

The table 8.29 shows that respondent of 42.6% told traditional healings cheaper than modern medicines. The 35.7% respondents found both (traditional & modern) medications are

expensive and only 17.6% respondents found allopathic (modern) medication as cheaper. VDC wise, respondents from Nibuwakharka (52.6%), Malungga (51.9%), Chandibhanjyang (50%) were higher percentage in cheaper traditional medication and respondents from Birgha (75%) were higher percentage in both are expensive.

The Chi-Square (χ^2) test shows that there was significant association ($\chi^2 = 112.246$, $df = 24$ and $p = .000$, which is less than .05) found between the respondents of different VDC wise groups in their affording practices on cost comparison in between traditional and modern medication.

8.6 Home Visiting Health Services in Villages

In Nepal, there are several NGOs/INGOs and private sectors which are providing health services. In villages, health workers of NGOs/INGOs and medicine sellers, agents of private health sectors are doing home visits. Among them, some organizations provide health services, health camps, etc. Here, the situation of home visits from the NGOs/INGOs and private sectors are discussed.

8.6.1 Home Visit Service from the NGO/INGO Health Workers

In Nepal, there are so many non-governmental organizations providing preventive, health promotion, curative and rehabilitative health services from an individual level to community. The accessibility of the Magars to NGOs/INGO's health services (preventive and curative) in the villages is discussed here.

The VDC wise response about the exposing health care of NGO/INGOs in Magar villages is presented in table 8.30:

Table 8.30: Respondents Access towards NGO/INGO Health Care by Education and Language

VDC		Response					Total	Pearson Chi-Square
		Do come in household	Do come in village	Do come sometimes	Don't come	Don't Know		
Alamdevi	Count	4	3	44	24	12	87	Asymp. Sig. (2-sided) .000
	%	4.6	3.4	50.6	27.6	13.8	100	
Birgha	Count	11	2	41	10	0	64	
	%	17.2	3.1	64.1	15.6	0.0	100	
Chandi Bhanjyang	Count	2	2	3	50	23	80	
	%	2.5	2.5	3.8	62.5	28.8	100	
Jagatradevi	Count	5	98	13	4	2	122	
	%	4.1	80.3	10.7	3.3	1.6	100	
Malungga	Count	4	19	3	0	1	27	
	%	14.8	70.4	11.1	0.0	3.7	100	
Nibuwakharka	Count	8	26	6	13	4	57	
	%	14.0	45.6	10.5	22.8	7.0	100	
Pelakot	Count	2	25	6	15	6	54	
	%	3.7	46.3	11.1	27.8	11.1	100	
Pindikhola	Count	6	20	5	1	5	37	
	%	16.2	54.1	13.5	2.7	13.5	100	
Shree Krishna Gandaki	Count	2	1	8	93	4	108	
	%	1.9	0.9	7.4	86.1	3.7	100	
Total	Count	44	196	129	210	57	636	
	%	6.9	30.8	20.3	33.0	9.0	100	

Source: Field Survey, 2015.

The table 8.30 shows that respondents of VDC's *Malungga*, *Jagatradevi* and *Birgha* were higher in percentage in familiar with NGOs/INGOs health programs at the village. The VDCs

Malungga and *Jagatradevi* lie on the *Sidhartha* highway. *Birgha* is the centre and old headquarter of local areas. Religion-wise, the respondents who were unknown their religious groups, traditional/ animist groups have a higher percentage being exposed with NGO/INGO's health programs.

The Chi-Square (χ^2) test shows that there was a significant association ($\chi^2 = 606.538$, $df = 32$ and $p = .000$, which is less than .05) found between the respondents of different VDC-wise groups in their exposure to NGO/INGO's health services in the villages.

8.6.2 Medical Traders in Villages

In villages, several traders are presented to sell their goods and such types of goods purchases from the villagers to fulfil their necessities in the study area. This type of business in the villages is expanded for healings and health goods too. Several traders are selling their health-related goods, healing medicines, herbs and shrubs in the villages. The travelling traders visiting villages to sell medicines door-to-door or give health service is discussed here and the result is presented in table 8.31:

Table 8.29: The Situation of Medicinal Drugs Selling or Health Service from Traders at Home

VDC		Response		Total	Pearson Chi-Square
		Yes	No		
Alamdevi	Count	79	8	87	Asymp. Sig. (2-sided) .000
	% within VDC	90.8	9.2	100	
Birgha	Count	62	2	64	
	% within VDC	96.9	3.1	100	
ChandiBhanjyang	Count	33	47	80	
	% within VDC	41.3	58.8	100	
Jagatradevi	Count	116	6	122	
	% within VDC	95.1	4.9	100	
Malungga	Count	24	3	27	
	% within VDC	88.9	11.1	100	
Nibuwakharka	Count	55	2	57	
	% within VDC	96.5	3.5	100	
Pelakot	Count	51	3	54	
	% within VDC	94.4	5.6	100	
Pindikholā	Count	35	2	37	
	% within VDC	94.6	5.4	100	
Shree Krishna Gandaki	Count	101	7	108	
	% within VDC	93.5	6.5	100	
Total	Count	556	80	636	
	% within VDC	87.4	12.6	100	

Source: Field Survey, 2015.

The table 7.31 shows that, 87.4% of respondents have seen traders selling medicines or providing health cares in door-to-door service and 12.6% of respondents had not seen such types of traders at the village. VDC-wise, the respondents from Birgha (96.9%),

Nibuwakharka (96.5%), and Jagatradevi (95.1%) were higher in percentage having seen traders selling medicine or providing health care services at the doors in the village. Religion-wise, the respondents who had no idea of their own religion (95.0%), and traditional or animist (93.8%), Hindu (89%) were higher in percentages in having seen the traders selling medicines or providing health care service at homes in the village.

The Chi-Square (χ^2) test shows that there was a significant association ($\chi^2= 179.830$, $df = 8$ and $p = .000$, which is less than .05) found between the respondents of different VDC wise groups in their encounter or having seen on traders selling drugs or providing health care door-to-door in the villages.

8.6.2.1 Types of Medical Traders

There are several types of health care traders roaming in the villages for their trades and businesses. Some are herbal medicine sellers, food supplement sellers, however, a few are qualified health workers, NGO/INGO's health workers and some may be quack (Jhole) doctors. Here, the types of health care traders roaming in the village for their business are discussed and the result is presented in table 8.32:

Table 8.32: Types of Medical Traders who Sell Medicine or Health Care Services in the Village

VDC	Types of Medical Traders				Total	Pearson Chi-Square
	Herbal medicine seller	Health workers of institutions	Jhole Doctors			
Alamdevi	Count	74	5	0	79	Asymp. Sig. (2-sided) .000
	% within VDC	93.7	6.3	0.0	100	
Birgha	Count	61	0	1	62	
	% within VDC	98.4	0.0	1.6	100	
ChandiBhanjyna	Count	29	2	2	33	
	% within VDC	87.9	6.1	6.1	100	
Jagatradevi	Count	63	53	0	116	
	% within VDC	54.3	45.7	0.0	100	
Malungga	Count	14	10	0	24	
	% within VDC	58.3	41.7	0.0	100	
Nibuwakharka	Count	40	15	0	55	
	% within VDC	72.7	27.3	0.0	100	
Pelakot	Count	47	4	0	51	
	% within VDC	92.2	7.8	0.0	100	
Pindikholahola	Count	25	9	1	35	
	% within VDC	71.4	25.7	2.9	100	
Shree Krishna Gandaki	Count	98	2	1	101	
	% within VDC	97.0	2.0	1.0	100	
Total	Count	451	100	5	556	
	% within VDC	81.1	18.0	0.9	100	

Source: Field Survey, 2015.

The table 8.32 shows that the majority of respondents (81.1%) found the presence of herbal medicine selling traders in the villages and 18% of respondents found a presence of health workers of the organizations or private institutions selling health care services at home. Jhole doctors are quack doctors who roam individually carrying drugs in their bags. They are mostly found in India-Nepal boarder villages. However, in the study area, this problem is found extremely less than other places of Nepal, especially the Terai belt. The VDC-wise respondents of Birgha (98.4%), Shrikrishna Gandaki (97%), Alamdevi (93.7%), Pelakot (92.2%) have a higher percentage in encountering or meeting with herbal medicine sellers in the villages and Jagatradevi (45.7%) and Malungga (41.7%) were higher in percentage in encountering or meeting with institutional health workers selling their health services in the village as home services. It means, the health workers of governmental institutions or private institutions provide home services for gaining money. Likewise, in the highway area, there are more health institutions than in the distance from the highway.

The Chi-Square (χ^2) test shows that there was a significant association ($\chi^2= 132.981$, $df = 16$ and $p = .000$, which is less than .05) found between the respondents of different VDC wise groups in their exposing to medical traders or paying health care provider in the villages.

8.7 Practices on Maternal and Child Health

Maternal and child health (MCH) is a major issue in public health and social health. In this section childbirth situation, child birthplace, home delivery practice, assistance to childbirth in delivery period, the custom of umbilical dispose, and vaccination patterns are discussed. The traditional concepts of health care in MCH is changing; especially in sanitation, food nutrition of mother and consumption of new technologies. Modern science has innovated new technologies in the maternal and child health sectors. In contrast, such facilities in remote areas are limited. Most of them are accumulated in urban areas and administrative headquarters.

8.7.1 Situation of Having Child Birth in Households

To know childbirth practices among the Magars, firstly, it is required to find out having childbirth within the past five years of the survey period. So, having childbirth in the surveyed households is discussed here. The distribution of having childbirth in the respondents' households is presented in table 8.33:

Table 8.7.1: The Distribution of Having Childbirth within Five Years

VDC	Having Child Birth		Having not Child Birth		Total	
	Count	%	Count	%	Count	%
Alamdevi	29	33.3	58	66.7	87	100
Birgha	19	29.7	45	70.3	64	100
ChandiBhanjyna	25	31.3	55	68.8	80	100
Jagatradevi	34	27.9	88	72.1	122	100
Malungga	11	40.7	16	59.3	27	100
Nibuwakharka	19	33.3	38	66.7	57	100
Pelakot	19	35.2	35	64.8	54	100
Pindikhola	12	32.4	25	67.6	37	100
Shreekrishna Gandaki	36	33.3	72	66.7	108	100
Total	204	32.1	432	67.9	636	100

Source: Field Survey, 2015.

The table 8.33 shows that only 32.1% (or 204) of respondent's households were having childbirth in the past five years of the survey date. And, 432 (or 67.9%) household respondents shared that they had not childbirth within the past five years of the survey date.

8.7.2 Place of Giving Child Birth

In the survey, 32.1% (or 204) of respondents' households have childbirth within the past five years of the survey date. Among those mothers, the service achieved place and health institutions are discussed here. The income source-wise distribution of childbirth giving place, pattern of going health institutions are presented in table 8.34:

Table 8.34: Distribution of Place of Giving Birth Practice by Income Source of Household

Income Source of Household		Place of Giving Birth					Total	Pearson Chi-Square
		at Home	Local Govt. health institution	Pharmacy/Clinic	Private /Non-Govt hospital	Zonal Hospital , Butwal		
Agriculture	Count	5	3	0	1	0	9	Asym p. Sig. (2-sided) .003
	%	55.6	33.3	0.0	11.1	0.0	100	
Agriculture, labour or wage's works, Skill works	Count	5	1	1	3	1	11	
	%	45.5	9.1	9.1	27.3	9.1	100	
Agriculture, Private Job in India or equivalence	Count	5	0	1	22	0	28	
	%	17.9	0.0	3.6	78.6	0.0	100	
Agriculture, Business/ small Entrepreneurships	Count	7	2	2	2	0	13	
	%	53.8	15.4	15.4	15.4	0.0	100	
Agriculture, Service/ Jobs in other sectors	Count	3	0	0	3	0	6	
	%	50.0	0.0	0.0	50.0	0.0	100	
Agriculture, teacher/Nepal Army/Police/Govt. Job/Pension	Count	3	1	3	5	0	12	
	%	25.0	8.3	25.0	41.7	0.0	100	
Other sources not including Agriculture (e.g. Job, foreign employment, Business etc)	Count	8	1	3	1	0	13	
	%	61.5	7.7	23.1	7.7	0.0	100	
Agriculture, Foreign employment (Gulf, Malaysia or equivalent)	Count	15	4	8	24	0	51	
	%	29.4	7.8	15.7	47.1	0.0	100	
Agriculture, Indian Army/police or Pension	Count	24	2	6	24	0	56	
	%	42.9	3.6	10.7	42.9	0.0	100	
Agriculture, Foreign Employment (Korea, Afghanistan, Iraq, Europe, America or equivalent)	Count	0	0	1	1	0	2	
	%	0.0	0.0	50.0	50.0	0.0	100	
Agriculture, British Army/Singapore Police or Pensioner	Count	1	0	0	2	0	3	
	%	33.3	0.0	0.0	66.7	0.0	100	
Total	Count	76	14	25	88	1	204	
	%	37.3	6.9	12.3	43.1	0.5	100	

Source: Field Survey, 2015.

The table 8.34 shows that the majority of respondents (private/non-government health institution 43.1%, and pharmacy/clinic 12.3%) were found gone at the private sector to give birth and 37.3% respondents had given birth at home. Only 6.9% of respondents' households had gone to the government health institutions for giving childbirth. The income source of household-wise respondents from other sources not including agriculture (e.g., job, foreign employment, business, etc) (61.5%), agriculture (55.6%), and agriculture with business/ small entrepreneurship (53.8%) were higher in percentage in doing delivery at home in the last five years of the survey.

The Chi-Square (χ^2) test shows that there was a significant association ($\chi^2= 69.122$, $df = 40$ and $p = .003$, which is less than .05) found between the respondents of *different income source of household*-wise groups in their practices on giving child birthplaces within past five years of the survey period. The VDC wise practice of giving birthplace of respondent's households in presented in table 8.35:

Table 8.35: Distribution of Place of Giving Birth Practice in VDC settlement

VDC		Place of Giving Birth					Total	Pearson Chi-Square
		at Home	Local Govt. health institution	Pharmacy/Clinic	Private/Non-Govt hospital	Zonal Hospital, Butwal		
Alamdevi	Count	13	2	4	12	0	31	Asymp . Sig. (2-sided) .013
	%	41.9	6.5	12.9	38.7	0.0	100	
Birgha	Count	9	5	0	5	0	19	
	%	47.4	26.3	0.0	26.3	0.0	100	
Chandi Bhanjyang	Count	5	5	3	11	1	25	
	%	20.0	20.0	12.0	44.0	4.0	100	
Jagatradevi	Count	12	0	8	14	0	34	
	%	35.3	0.0	23.5	41.2	0.0	100	
Malungga	Count	2	1	0	8	0	11	
	%	18.2	9.1	0.0	72.7	0.0	100	
Nibuwakharka	Count	10	0	0	10	0	20	
	%	50.0	0.0	0.0	50.0	0.0	100	
Pelakot	Count	9	0	2	7	0	18	
	%	50.0	0.0	11.1	38.9	0.0	100	
Pindikholahola	Count	4	0	1	7	0	12	
	%	33.3	0.0	8.3	58.3	0.0	100	
Shree Krishna Gandaki	Count	12	1	7	14	0	34	
	%	35.3	2.9	20.6	41.2	0.0	100	
Total	Count	76	14	25	88	1	204	
	%	37.3	6.9	12.3	43.1	0.5	100	

Source: Field Survey, 2015.

The table 8.35 shows that VDC-wise respondents of Nibuwakharka (50%), Pelakot (50%) were higher in percentage and Malungga (18.2%) counted the lowest percentage in childbirth giving at home. Malungga VDC has governmental well-equipped PHC.

The Chi-Square (χ^2) test shows that there was a significant association ($\chi^2= 52.474$, $df = 32$ and $p = .013$, which is less than .05) found between the respondents of different VDC-wise groups in their practices on giving child birthplaces within the past five years of the survey period.

8.7.3 Practice of Taking Assistance in Giving Child Birth at Home

Among the 204 households having childbirth within the past five years, only 76 households had a delivery at home. Here, the assistance taken practices to achieve health and wellbeing in the childbirth period is discussed.

The age and VDC wise response and associations in local practice of giving assistance in childbirth for pregnant women are presented table 8.36:

Table 8.36: Distribution of Practice of Assisting in Childbirth by Age and VDC

Age		Practice of Giving Assistance in Childbirth					Total	Pearson Chi-Square
		Mature females of family/ kinship	Traditional Birth Attendance/ Sudeni	Female Health Volunteers	Inviting health worker	Self give birth		
Under 25	Count	0	1	4	5	1	11	Asymp. Sig. (2-sided) .014
	%	0.0	9.1	36.4	45.5	9.1	100	
26 - 35	Count	14	1	3	3	3	24	
	%	58.3	4.2	12.5	12.5	12.5	100	
36 - 45	Count	4	1	0	2	5	12	
	%	33.3	8.3	0.0	16.7	41.7	100	
46 - 55	Count	3	1	3	0	1	8	
	%	37.5	12.5	37.5	0.0	12.5	100	
56 - 65	Count	4	4	1	2	0	11	
	%	36.4	36.4	9.1	18.2	0.0	100	
66 & above	Count	4	1	1	3	1	10	
	%	40.0	10.0	10.0	30.0	10.0	100	
Total	Count	29	9	12	15	11	76	
	%	38.2	11.8	15.8	19.7	14.5	100	
VDC								
Alamdevi	Count	3	2	4	1	3	13	Asymp. Sig. (2-sided) .004
	%	23.1	15.4	30.8	7.7	23.1	100	
Birgha	Count	4	1	1	3	0	9	
	%	44.4	11.1%	11.1	33.3	0.0	100	
ChandiBhanjyang	Count	0	0	2	1	2	5	
	%	0.0	0.0	40.0	20.0	40.0	100	
Jagatradevi	Count	3	0	1	6	2	12	
	%	25.0	0.0	8.3	50.0	16.7	100	
Malungga	Count	0	1	1	0	0	2	
	%	0.0	50.0	50.0	0.0	0.0	100	
Nibuwakharka	Count	9	1	0	0	0	10	
	%	90.0	10.0	0.0	0.0	0.0	100	
Pelakot	Count	6	3	0	0	0	9	
	%	66.7	33.3	0.0	0.0	0.0	100	
Pindikholi	Count	0	1	0	1	2	4	
	%	0.0	25.0	0.0	25.0	50.0	100	
Shree Krishna Gandaki	Count	4	0	3	3	2	12	
	%	33.3	0.0	25.0	25.0	16.7	100	
Total	Count	29	9	12	15	11	76	
	%	38.2	11.8	15.8	19.7	14.5	100	

Source: Field Survey, 2015.

The table 8.36 shows that the respondents of households 38.2% told taking assistance from senior females from the family or kinship, 11.8% households had taken assistance of traditional birth attendance (*sudeni*), 15.8% household were assisted from female health volunteers, 14.5% households had taken assistance from the health workers and 14.5% households had not taken any assistance.

The Chi-Square (χ^2) test shows that there was a significant association ($\chi^2= 36.451$, $df = 20$ and $p = .014$, which is less than .05) found between the respondents of different *age*-wise groups in their practices on providing assistance when giving childbirth at home. Similarly, that there was a significant association ($\chi^2= 57.374$, $df = 32$, and $p = .004$, which is less than .05) found between the respondents of different *VDC*wise groups in their practices on providing assistance when giving childbirth at home.

The income source of household wise response and association in local practice of giving assistance in childbirth for pregnant women is presented table 8.37:

Table 8.37: Distribution of Practice of Giving Assistance in Childbirth by Income Source of Household

Income Source of Household		Practice of Giving Assistance in Childbirth					Total	Pearson Chi-Square
		Mature females of family/kinship	Traditional Birth Attendance/Sudeni	Female Health Volunteers	Inviting health worker	Self give birth		
Agriculture	Count	1	0	1	0	3	5	Asymp . Sig. (2-sided) .016
	%	20.0	0.0	20.0	0.0	60.0	100	
Agriculture, labour or wage's works, Skill works	Count	1	2	1	0	1	5	
	%	20.0	40.0	20.0	0.0	20.0	100	
Agriculture, Private Job in India or equivalence	Count	2	0	0	1	2	5	
	%	40.0	0.0	0.0	20.0	40.0	100	
Agriculture, Business/ small Entrepreneurships	Count	2	1	2	1	1	7	
	%	28.6	14.3	28.6	14.3	14.3	100	
Agriculture, Service/ Jobs in other sector	Count	1	2	0	0	0	3	
	%	33.3	66.7	0.0	0.0	0.0	100	
Agriculture, teacher/Nepal Army/Police/Govt. Job/Pension	Count	1	1	0	0	1	3	
	%	33.3	33.3	0.0	0.0	33.3	100	
Other sources not including Agriculture (e.g. Job, foreign employment, Business etc)	Count	6	0	1	1	0	8	
	%	75.0	0.0	12.5	12.5	0.0	100	
Agriculture, Foreign employment (Gulf, Malaysia or equivalent)	Count	9	1	2	1	2	15	
	%	60.0	6.7	13.3	6.7	13.3	100	
Agriculture, Indian Army/ police or Pension	Count	6	2	4	11	1	24	
	%	25.0	8.3	16.7	45.8	4.2	100	
Agriculture, British Army/Singapore Police or Pensioner	Count	0	0	1	0	0	1	
	%	0.0	0.0	100.0	0.0	0.0	100	
Total	Count	29	9	12	15	11	76	
	%	38.2	11.8	15.8	19.7	14.5	100	

Source: Field survey, 2015.

The table 8.37 shows that the respondent's households having an income source as agriculture with Indian army/police or pension (45.8%) were higher in percentage in inviting health workers for assisting childbirth at home. The Chi-Square (χ^2) test shows that there was a significant association ($\chi^2= 56.479$, $df = 36$ and $p = .016$, which is less than .05) found

between the respondents of different *income source of household-wise* groups in their practices on providing assistance when giving childbirth at home.

8.7.4 Newborn Baby Bathing Practices

In the villages, bathing for a new born baby is in practice after giving birth to a child. Generally, the villagers think that bathing is to make clean toa baby, however, there might be a risk of pneumonia or other respiratory infections. Here, bathing practices for a new born baby is discussed.

The age and education-wise perception and associations of practices about time duration of the bathing for a new born baby are presented in table 8.38:

Table 8.38: Perception of Practice about Time Duration for new born Baby Bathing by Age and Education

Age		Newborn Baby Bathing Time Duration						Total	Pearson Chi-Square	
		Immediately of Birth	2 - 4 Hours of after Birth	Within 24 hours of Birth	After 2-3 days of Birth	After 4 -5 days of Birth	After a week of Birth			Don't Know
Under 25	Count	6	5	15	0	1	7	6	40	Asym p. Sig. (2-sided) .002
	%	15.0	12.5	37.5	0.0	2.5	17.5	15.0	100	
26 - 35	Count	49	6	44	2	7	11	10	129	
	%	38.0	4.7	34.1	1.6	5.4	8.5	7.8	100	
36 - 45	Count	73	5	38	2	7	10	10	145	
	%	50.3	3.4	26.2	1.4	4.8	6.9	6.9	100	
46 - 55	Count	70	8	31	1	4	6	10	130	
	%	53.8	6.2	23.8	0.8	3.1	4.6	7.7	100	
56 - 65	Count	65	10	23	1	3	3	6	111	
	%	58.6	9.0	20.7	0.9	2.7	2.7	5.4	100	
66 & above	Count	50	6	13	1	2	1	8	81	
	%	61.7	7.4	16.0	1.2	2.5	1.2	9.9	100	
Total	Count	313	40	164	7	24	38	50	636	
	%	49.2	6.3	25.8	1.1	3.8	6.0	7.9	100	
Education Level										
Illiterate	Count	53	11	14	1	0	1	9	89	Asym p. Sig. (2-sided) .000
	%	59.6	12.4	15.7	1.1	0.0	1.1	10.1	100	
Literate/ Primary	Count	151	14	71	4	9	8	18	275	
	%	54.9	5.1	25.8	1.5	3.3	2.9	6.5	100	
Lower Secondary	Count	46	1	26	1	6	9	12	101	
	%	45.5	1.0	25.7	1.0	5.9	8.9	11.9	100	
Secondary	Count	44	8	40	1	8	11	3	115	
	%	38.3	7.0	34.8	0.9	7.0	9.6	2.6	100	
Certificate Level/+2	Count	14	5	10	0	1	5	5	40	
	%	35.0	12.5	25.0	0.0	2.5	12.5	12.5	100	
Bachelor & above	Count	5	1	3	0	0	4	3	16	
	%	31.3	6.3	18.8	0.0	0.0	25.0	18.8	100	
Total	Count	313	40	164	7	24	38	50	636	
	%	49.2	6.3	25.8	1.1	3.8	6.0	7.9	100	

Source: Field Survey, 2015.

The table 8.38 shows that the respondents of 49.2% opined for immediately, 6.3% told 2-4 hours and 25.8% respondents did it within 24 hours. Hence, the majority of respondents perceived the practice of bathing within the birthing day for new born babies. Only 7.9% of respondents told about the bathing practice after one week of birth. Age-wise, the respondents of increasing age or older age groups of respondents were found increasing percentage in immediately bathing after the birth of a new born baby. Education-wise, decreasing level of education increasing the percentage in immediately bathing after birth for a new born baby and increasing education level there was found increasing percentage bathing after one week of birth for a new born baby.

The Chi-Square (χ^2) test shows that there was a significant association ($\chi^2= 57.531$, $df = 30$ and $p = .002$, which is less than .05) found between the respondents of different *age-wise* groups in their perception on time duration for new born baby bathing practices. Similarly, there was a significant association ($\chi^2= 74.589$, $df = 30$, and $p = .000$, which is less than .05) found between the respondents of different *education level-wise* groups in their perception on time duration for new born baby bathing practices.

The marital status and VDC wise perception and associations of practices about time duration of the bathing for a new born baby is presented in table 8.39:

Table 8.39: Perception of Practice about Time Duration for Newborn Baby Bathing by Marital Status and VDC Location

Marital Status		Newborn Baby Bathing Time Duration							Total	Pearson Chi-Square
		Immediately of Birth	2 - 4 Hours of after Birth	Within 24 hours of Birth	After 2-3 days of Birth	After 4 -5 days of Birth	After a week of Birth	Don't Know		
Married	Count	249	27	143	6	20	35	42	522	Asym p. Sig. (2-sided) .001
	%	47.7	5.2	27.4	1.1	3.8	6.7	8.0	100	
Unmarried	Count	4	3	2	0	1	3	2	15	
	%	26.7	20.0	13.3	0.0	6.7	20.0	13.3	100	
Single (Widow/Widower)	Count	60	9	19	1	3	0	6	98	
	%	61.2	9.2	19.4	1.0	3.1	0.0	6.1	100	
Divorced	Count	0	1	0	0	0	0	0	1	
	%	0.0	100.0	0.0	0.0	0.0	0.0	0.0	100	
Total	Count	313	40	164	7	24	38	50	636	
	%	49.2	6.3	25.8	1.1	3.8	6.0	7.9	100	
VDC										
Alamdevi	Count	41	12	5	2	6	9	12	87	Asym p. Sig. (2-sided) .000
	%	47.1	13.8	5.7	2.3	6.9	10.3	13.8	100	
Birgha	Count	38	0	26	0	0	0	0	64	
	%	59.4	0.0	40.6	0.0	0.0	0.0	0.0	100	
Chandibhanjyang	Count	57	5	17	0	0	1	0	80	
	%	71.3	6.3	21.3	0.0	0.0	1.3	0.0	100	

Jagatrad evi	Count	58	4	38	0	9	10	3	122
	%	47.5	3.3	31.1	0.0	7.4	8.2	2.5	100
Malung ga	Count	12	0	5	0	1	4	5	27
	%	44.4	0.0	18.5	0.0	3.7	14.8	18.5	100
Nibuwak harka	Count	21	0	17	4	4	6	5	57
	%	36.8	0.0	29.8	7.0	7.0	10.5	8.8	100
Pelakot	Count	44	2	2	0	0	0	6	54
	%	81.5	3.7	3.7	0.0	0.0	0.0	11.1	100
Pindikh ola	Count	25	2	7	0	0	2	1	37
	%	67.6	5.4	18.9	0.0	0.0	5.4	2.7	100
Shree Krishna Gandaki	Count	17	15	47	1	4	6	18	108
	%	15.7	13.9	43.5	0.9	3.7	5.6	16.7	100
Total	Count	313	40	164	7	24	38	50	636
	%	49.2	6.3	25.8	1.1	3.8	6.0	7.9	100

Source: Field Survey, 2015.

The table 8.39 shows that marital status-wise, the respondents of single (widow/widower) (61.2%) and VDC-wise, Pelakot (81.5%) were higher in percentage in immediately bathing after the birth of a new born baby.

The Chi-Square (χ^2) test shows that there was a significant association ($\chi^2= 42.252$, $df = 18$ and $p = .001$, which is less than .05) found between the respondents of different *marital status* wise groups in their perception on time duration for new born baby bathing practices. Similarly, there was a significant association ($\chi^2= 221.350$, $df = 48$ and $p = .000$, which is less than .05) found between the respondents of different *VDC* wise groups in their perception on time duration for new born baby bathing practices.

8.7.5 Cultural Practices of Disposing Umbilical Cord

The new born baby's cord is cut few inches long and tied with thread and after few days that long cord falls and is culturally disposed. This practice is connected with the belief of well beings among the Magars. There is a belief that if the fallen cord is buried near hearth/oven, that child will arrive at home at mealtime. Likewise, if it is buried where drips fall from eaves (*baleni*), the child always returns home in time. Similarly, they keep safely some parts of the cord and use in making *Jantar* (bless charm) too. Here, the cultural practice of disposing of umbilical cords is discussed.

The age and education-wise perception and associations of cultural practices about the disposing of the fallen umbilical cord from a new born baby are presented in table 8.40:

Table 8.40: Cultural Practices of Disposing of Fallen Umbilical Cord by Age and Education

Age		Cultural Practice of Managing Fallen Cord of Baby						Total	Pearson Chi-Square
		Buried near the hearth/ Oven	Kept safely	Thrown any where	Buried in near hearth and kept safely both	Buried at drips from eaves (Baleni)	Don't Know		
Under 25	Count	11	20	1	5	0	3	40	Asymp. Sig. (2-sided) .000
	%	27.5	50.0	2.5	12.5	0.0	7.5	100	
26 - 35	Count	50	55	7	13	1	3	129	
	%	38.8	42.6	5.4	10.1	0.8	2.3	100	
36 - 45	Count	76	33	11	21	2	2	145	
	%	52.4	22.8	7.6	14.5	1.4	1.4	100	
46 - 55	Count	68	27	16	14	2	3	130	
	%	52.3	20.8	12.3	10.8	1.5	2.3	100	
56 - 65	Count	63	28	8	9	2	1	111	
	%	56.8	25.2	7.2	8.1	1.8	0.9	100	
66 & above	Count	55	12	4	3	4	3	81	
	%	67.9	14.8	4.9	3.7	4.9	3.7	100	
Total	Count	323	175	47	65	11	15	636	
	%	50.8	27.5	7.4	10.2	1.7	2.4	100	
Education Level									
Illiterate	Count	61	11	5	8	2	2	89	Asymp. Sig. (2-sided) .000
	%	68.5	12.4	5.6	9.0	2.2	2.2	100	
Literate/Primary	Count	145	63	23	33	6	5	275	
	%	52.7	22.9	8.4	12.0	2.2	1.8	100	
Lower Secondary	Count	48	26	11	11	2	3	101	
	%	47.5	25.7	10.9	10.9	2.0	3.0	100	
Secondary	Count	51	44	7	10	1	2	115	
	%	44.3	38.3	6.1	8.7	0.9	1.7	100	
Certificate Level/+2	Count	12	23	0	3	0	2	40	
	%	30.0	57.5	0.0	7.5	0.0	5.0	100	
Bachelor & above	Count	6	8	1	0	0	1	16	
	%	37.5	50.0	6.3	0.0	0.0	6.3	100	
Total	Count	323	175	47	65	11	15	636	
	%	50.8	27.5	7.4	10.2	1.7	2.4	100	

Source: Field Survey, 2015.

The table 8.40 shows that the majority of respondents accepted the cultural practice of burying near the hearth (50.8%) and burying near the hearth and keeping safely (10.2%). The 27.5% of respondents told about the cultural practice of keeping it safe for future use. Age-wise; increasing age or older age groups and education-wise; lower education level group respondents told buried near the hearth to manage fallen umbilical cord of a new born baby.

The Chi-Square (χ^2) test shows that there was a significant association ($\chi^2 = 66.489$, $df = 25$ and $p = .000$, which is less than .05) found between the respondents of different age-wise groups in their cultural practices on disposing fallen umbilical cord from the new born baby.

Similarly, there was a significant association ($\chi^2 = 55.071$, $df = 25$ and $p = .000$, which is less than .05) found between the respondents of different *education level*-wise groups in their cultural practices on disposing of the fallen umbilical cord from the new born baby.

VDC and religion-wise perception and associations of cultural practices about the disposing of the fallen umbilical cord from a new born baby are presented in table 8.41:

Table 8.41: Cultural Practices of Disposing Fallen Umbilical Cord by VDC settlement and Religion

VDC		Cultural Practice of Managing Fallen Cord of Baby						Total	Pearson Chi-Square
		Buried near the hearth/ Oven	Kept safely	Thrown any where	Buried in near hearth and kept safely both	Buried at drips from eaves (Baleni)	Don't Know		
Alamdevi	Count	52	24	1	5	0	5	87	Asym p. Sig. (2-sided) .000
	%	59.8	27.6	1.1	5.7	0.0	5.7	100	
Birgha	Count	43	21	0	0	0	0	64	
	%	67.2	32.8	0.0	0.0	0.0	0.0	100	
ChandiBhanjyna	Count	60	17	2	1	0	0	80	
	%	75.0	21.3	2.5	1.3	0.0	0.0	100	
Jagatradevi	Count	34	48	24	11	1	4	122	
	%	27.9	39.3	19.7	9.0	0.8	3.3	100	
Malungga	Count	14	5	3	5	0	0	27	
	%	51.9	18.5	11.1	18.5	0.0	0.0	100	
Nibuwa kharka	Count	16	13	10	16	0	2	57	
	%	28.1	22.8	17.5	28.1	0.0	3.5	100	
Pelakot	Count	17	10	3	20	3	1	54	
	%	31.5	18.5	5.6	37.0	5.6	1.9	100	
Pindikholahola	Count	16	9	3	1	7	1	37	
	%	43.2	24.3	8.1	2.7	18.9	2.7	100	
Shree Krishna Gandaki	Count	71	28	1	6	0	2	108	
	%	65.7	25.9	0.9	5.6	0.0	1.9	100	
Total	Count	323	175	47	65	11	15	636	
	%	50.8	27.5	7.4	10.2	1.7	2.4	100	
Religion									Asym p. Sig. (2-sided) .045
Traditional or Animist	Count	74	29	18	19	3	3	146	
	%	50.7	19.9	12.3	13.0	2.1	2.1	100	
Buddhist	Count	51	23	3	6	1	1	85	
	%	60.0	27.1	3.5	7.1	1.2	1.2	100	
Hindu	Count	179	108	20	36	4	9	356	
	%	50.3	30.3	5.6	10.1	1.1	2.5	100	
Christian	Count	4	3	0	0	0	0	7	
	%	57.1	42.9	0.0	0.0	0.0	0.0	100	
Atheism/ Nastik	Count	0	2	0	0	0	0	2	
	%	0.0	100	0.0	0.0	0.0	0.0	100	
Don't Know	Count	15	10	6	4	3	2	40	
	%	37.5	25.0	15.0	10.0	7.5	5.0	100	
Total	Count	323	175	47	65	11	15	636	
	%	50.8	27.5	7.4	10.2	1.7	2.4	100	

Source: Field survey, 2015.

The table 8.41 shows that VDC-wise respondents from *Chandibhanjyang* (75%), *Birgha* (67.2%), and religion-wise, Buddhist (60%) were higher in percentage in the cultural practice of burying near the hearth to manage fallen umbilical cord of a new born baby.

The Chi-Square (χ^2) test shows that there was a significant association ($\chi^2 = 265.825$, $df = 40$ and $p = .000$, which is less than .05) found between the respondents of different *VDC* wise groups in their cultural practices on disposing fallen umbilical cord from the new born baby. Similarly, there was a significant association ($\chi^2 = 38.123$, $df = 25$ and $p = .045$, which is less than .05) found between the respondents of different *religion*-wise groups in their cultural practices on disposing fallen umbilical cord from the new born baby.

The occupation wise perception and associations of cultural practices about the disposing of fallen umbilical cord from the new born baby are presented in table 8.42:

Table 8.42: Cultural Practices of Disposing Fallen Umbilical Cord by Occupation

Occupation		Cultural Practice of Managing Fallen Cord of Baby						Total	Pearson Chi-Square
		Buried near the hearth/ Oven	Kept safely	Thrown anywhere	Buried in near hearth and kept safely both	Buried at drips from eaves (Baleni)	Don't Know		
Agriculture	Count	195	73	26	32	4	8	338	Asym p. Sig. (2-sided) .000
	%	57.7	21.6	7.7	9.5	1.2	2.4	100	
Job/ service in Nepal	Count	6	17	1	3	0	1	28	
	%	21.4	60.7	3.6	10.7	0.0	3.6	100	
Construction/ Maintenance	Count	6	7	1	3	3	0	20	
	%	30.0	35.0	5.0	15.0	15.0	0.0	100	
Business	Count	14	14	2	3	0	0	33	
	%	42.4	42.4	6.1	9.1	0.0	0.0	100	
Foreign Employment	Count	17	4	3	6	0	2	32	
	%	53.1	12.5	9.4	18.8	0.0	6.3	100	
Job in India	Count	8	6	1	7	1	0	23	
	%	34.8	26.1	4.3	30.4	4.3	0.0	100	
House wife	Count	19	18	5	2	0	1	45	
	%	42.2	40.0	11.1	4.4	0.0	2.2	100	
Ex-Army/ Pensioner/Army in India or UK	Count	55	31	8	8	3	2	107	
	%	51.4	29.0	7.5	7.5	2.8	1.9	100	
Others	Count	3	5	0	1	0	1	10	
	%	30.0	50.0	0.0	10.0	0.0	10.0	100	
Total	Count	323	175	47	65	11	15	636	
	%	50.8	27.5	7.4	10.2	1.7	2.4	100	

Source: Field survey, 2015.

The table 8.42 shows that occupation-wise respondents from agriculture (57.7%), Ex-Army/ Pensioner /Army in India or the UK (51.4%) were higher in percentage in cultural practice of burying near the hearth to manage fallen umbilical cord of a new born baby.

The Chi-Square (χ^2) test shows that there was a significant association ($\chi^2= 87.509$, $df = 40$ and $p = .000$, which is less than $.05$) found between the respondents of different *occupation* wise groups in their cultural practices on disposing of fallen umbilical cord from the new born baby.

The income source of household wise perception and associations of cultural practices about the disposing fallen umbilical cord from a new born baby is presented in table 8.43:

Table 8.43: Cultural Practices of Disposing Fallen Umbilical Cord by Income Source of Household

Income Source of Household		Cultural Practice of Managing Fallen Cord of Baby						Total	Pearson Chi-Square
		Buried near the hearth/ Oven	Kept safely	Thrown any where	Buried in near hearth and kept safely both	Buried at drips from eaves (Baleni)	Don't Know		
Agriculture	Count	53	12	2	5	0	3	75	Asymp. Sig. (2-sided) .000
	%	70.7	16.0	2.7	6.7	0.0	4.0	100	
Agriculture, labour or wage's works, Skill works	Count	15	10	3	4	2	1	35	
	%	42.9	28.6	8.6	11.4	5.7	2.9	100	
Agriculture, Private Job in India or equivalence	Count	29	18	7	11	1	2	68	
	%	42.6	26.5	10.3	16.2	1.5	2.9	100	
Agriculture, Business/ small Entrepreneurships	Count	14	9	4	1	0	0	28	
	%	50.0	32.1	14.3	3.6	0.0	0.0	100	
Agriculture, Service/ Jobs in other sectors	Count	8	6	3	2	1	0	20	
	%	40.0	30.0	15.0	10.0	5.0	0.0	100	
Agriculture, teacher/Nepal Army/Police/Govt . Job/Pension	Count	25	12	9	5	2	2	55	
	%	45.5	21.8	16.4	9.1	3.6	3.6	100	
Other sources not including Agriculture (e.g. Job, foreign employment, Business etc)	Count	17	16	1	8	0	0	42	
	%	40.5	38.1	2.4	19.0	0.0	0.0	100	
Agriculture, Foreign employment (Gulf, Malaysia or equivalent)	Count	68	35	5	15	1	1	125	
	%	54.4	28.0	4.0	12.0	0.8	0.8	100	
Agriculture, Indian Army/police or Pension	Count	85	49	9	9	4	5	161	
	%	52.8	30.4	5.6	5.6	2.5	3.1	100	
Agriculture, Foreign Employment (Korea, Afghanistan, Iraq, Europe, America or equivalent)	Count	8	5	4	2	0	1	20	
	%	40.0	25.0	20.0	10.0	0.0	5.0	100	
Agriculture, British Army/Singapore Police or Pensioner	Count	1	3	0	3	0	0	7	
	%	14.3	42.9	0.0	42.9	0.0	0.0	100	
Total	Count	323	175	47	65	11	15	636	
	%	50.8	27.5	7.4	10.2	1.7	2.4	100	

Source: Field Survey, 2015.

The table 8.43 shows that income source of household-wise respondents from agriculture (70.7%) were higher percentage in the cultural practice of burying near the hearth to manage the fallen umbilical cord of a new born baby.

The Chi-Square (χ^2) test shows that there was a significant association ($\chi^2 = 74.908$, $df = 50$ and $p = .013$, which is less than .05) found between the respondents of different *income source of household* wise groups in their cultural practices on disposing fallen umbilical cord from the new born baby.

8.8 Vaccination Practice

The government of Nepal is providing free vaccines in support of donor agencies according to WHO instructions. The vaccination practice among the Magars is discussed here.

The age, education and marital status-wise response and associations in the practice of vaccination of respondent's household is presented in table 8.44:

Table 8.44: Practice of Vaccination among the Magars by Age, Education and Marital status

Age		Vaccination Practice				Total	Pearson Chi-Square
		No small children	Vaccine given	Not vaccinate	Don't know		
Under 25	Count	13	25	1	1	40	Asymp. Sig. (2-sided) .000
	%	32.5	62.5	2.5	2.5	100	
26 - 35	Count	35	88	0	5	128	
	%	27.3	68.8	0.0	3.9	100	
36 - 45	Count	48	89	2	6	145	
	%	33.1	61.4	1.4	4.1	100	
46 - 55	Count	64	61	0	5	130	
	%	49.2	46.9	0.0	3.8	100	
56 - 65	Count	43	53	4	11	111	
	%	38.7	47.7	3.6	9.9	100	
66 & above	Count	27	40	4	10	81	
	%	33.3	49.4	4.9	12.3	100	
Total	Count	230	356	11	38	635	
	%	36.2	56.1	1.7	6.0	100	
Education Level							
Illiterate	Count	24	48	4	13	89	Asymp. Sig. (2-sided) .000
	%	27.0	53.9	4.5	14.6	100	
Literate/ Primary	Count	112	140	5	18	275	
	%	40.7	50.9	1.8	6.5	100	
Lower Secondary	Count	44	55	0	2	101	
	%	43.6	54.5	0.0	2.0	100	
Secondary	Count	32	78	0	4	114	
	%	28.1	68.4	0.0	3.5	100	
Certificate Level/+2	Count	14	23	2	1	40	
	%	35.0	57.5	5.0	2.5	100	
Bachelor & above	Count	4	12	0	0	16	
	%	25.0	75.0	0.0	0.0	100	

Total	Count	230	356	11	38	635	
	%	36.2	56.1	1.7	6.0	100	
Marital Status							
Married	Count	190	301	9	22	522	Asymp. Sig. (2- sided) .024
	%	36.4	57.7	1.7	4.2	100	
Unmarried	Count	6	7	0	2	15	
	%	40.0	46.7	0.0	13.3	100	
Single (Widow/ Widower)	Count	33	48	2	14	97	
	%	34.0	49.5	2.1	14.4	100	
Divorced	Count	1	0	0	0	1	
	%	100	0.0	0.0	0.0	100	
Total	Count	230	356	11	38	635	
	%	36.2	56.1	1.7	6.0	100	

Source: Field Survey, 2015.

The table 8.44 shows that of 36.2% respondents' households did not have children, and the households who had children, majority of households (56.1%) were found to vaccinate their children. Age-wise, the respondents of younger age groups, and education-wise, having higher education level respondents' groups, and marital status-wise, married respondents have a higher percentage in giving immunization. In the household survey, not vaccinating for their children found, however, the government has been providing vaccination in free of cost. A similar result was also shown by the HDI reports of UNDP; lacking infants from immunization (% of one year old) DPT is 6% and measles 12% of one year old within Nepal (UNDP, 2016, p.228). Hence, some peoples are not going to immunization programs at the local level.

The Chi-Square (χ^2) test shows that there was a significant association ($\chi^2= 42.085$, $df = 15$ and $p = .000$, which is less than .05) found between the respondents of different *age*-wise groups in their cultural practices on vaccination for children. Similarly, there was a significant association ($\chi^2= 40.622$, $df = 15$ and $p = .000$, which is less than .05) found between the respondents of different education level-wise groups in their cultural practices on vaccination for children, and there was a significant association ($\chi^2=19.154$, $df = 9$ and $p = .024$, which is less than .05) found between the respondents of different *marital status* wise groups in their cultural practices on vaccination for children.

The type of family and religion-wise responses and associations in the practice of vaccination of respondent's household is presented in table 8.45:

Table 8.45: Practice of Vaccination among the Magars by Types of Family and Religion Status

Types of Family		Vaccination Practice				Total	Pearson Chi-Square	
		No small children	Vaccine given	Not vaccinate	Don't know			
Unitary	Count	134	128	6	10	278	Asymp. Sig. (2-sided) .000	
	%	48.2	46.0	2.2	3.6	100		
Joint	Count	96	228	5	28	357		
	%	26.9	63.9	1.4	7.8	100		
Total	Count	230	356	11	38	635		
	%	36.2	56.1	1.7	6.0	100		
Religion								
Traditional or Animist	Count	71	62	1	12	146		Asymp. Sig. (2-sided) .012
	%	48.6	42.5	0.7	8.2	100		
Buddhist	Count	31	51	2	1	85		
	%	36.5	60.0	2.4	1.2	100		
Hindu	Count	109	218	8	20	355		
	%	30.7	61.4	2.3	5.6	100		
Christian	Count	2	3	0	2	7		
	%	28.6	42.9	0.0	28.6	100		
Atheism/ Nastik	Count	1	1	0	0	2		
	%	50.0	50.0	0.0	0.0	100		
Don't Know	Count	16	21	0	3	40		
	%	40.0	52.5	0.0	7.5	100		
Total	Count	230	356	11	38	635		
	%	36.2	56.1	1.7	6.0	100		

Source: Field Survey, 2015.

The table 8.45 shows that types of family-wise, households from the joint family and religion-wise, households from Hindu and Buddhist were higher in percentage in giving vaccine for their children.

The Chi-Square (χ^2) test shows that there was a significant association ($\chi^2= 33.678$, $df = 3$ and $p = .000$, which is less than .05) found between the respondents of different *types of family-wise* groups in their cultural practices on vaccination for children. Similarly, there was a significant association ($\chi^2= 30.082$, $df = 15$, and $p = .012$, which is less than .05) found between the respondents of different *religion-wise* groups in their cultural practices on vaccination for children.

The type of VDC wise practice of vaccination of respondent's household is presented in table 8.46:

Table 8.46: VDC-wise Practice of Vaccination among the Magars by VDC Location

VDC		Vaccination Practice				Total	Pearson Chi-Square
		No small children	Vaccine given	Not vaccinate	Don't know		
Alamdevi	Count	42	37	1	6	86	Asymp. Sig. (2-sided) .012
	%	48.8	43.0	1.2	7.0	100	
Birgha	Count	3	55	1	5	64	
	%	4.7	85.9	1.6	7.8	100	
ChandiBhanjyang	Count	23	52	2	3	80	
	%	28.8	65.0	2.5	3.8	100	
Jagatradevi	Count	69	50	2	1	122	
	%	56.6	41.0	1.6	0.8	100	
Malungga	Count	6	19	1	1	27	
	%	22.2	70.4	3.7	3.7	100	
Nibuwakharka	Count	21	30	1	5	57	
	%	36.8	52.6	1.8	8.8	100	
Pelakot	Count	27	18	0	9	54	
	%	50.0	33.3	0.0	16.7	100	
Pindikholā	Count	23	12	0	2	37	
	%	62.2	32.4	0.0	5.4	100	
Shree Krishna Gandaki	Count	16	83	3	6	108	
	%	14.8	76.9	2.8	5.6	100	
Total	Count	230	356	11	38	635	
	%	36.2	56.1	1.7	6.0	100	

Source: Field Survey, 2015.

The table 8.46 shows that VDC-wise respondents' households of Birgha (85.9%), Shreekrishna Gandaki (76.9%) and Malungga (70.4%) were higher in percentage in giving vaccination for their children and these VDCs have better access to health facilities than other VDCS.

The Chi-Square (χ^2) test shows that there was a significant association ($\chi^2 = 119.568$, $df = 24$ and $p = .000$, which is less than .05) found between the respondents of different VDC-wise groups in their cultural practices on vaccination for children.

The income source of household wise responses and associations in the practice of vaccination of respondent's household is presented in table 8.47:

Table 8.47: Income Source of Household-wise Practice of Vaccination among the Magars

Income Source of Household		Vaccination Practice				Total	Pearson Chi-Square
		No small children	Vaccine given	Not vaccinate	Don't know		
Agriculture	Count	29	36	4	5	74	Asymp. Sig. (2-sided) .006
	%	39.2	48.6	5.4	6.8	100	
Agriculture, labour or wage's works, Skill works	Count	10	25	0	0	35	
	%	28.6	71.4	0.0	0.0	100	
Agriculture, Private Job in India or equivalence	Count	23	37	0	8	68	
	%	33.8	54.4	0.0	11.8	100	
Agriculture, Business/ small Entrepreneurships	Count	5	22	0	1	28	
	%	17.9	78.6	0.0	3.6	100	
Agriculture, Service/ Jobs in other sectors	Count	5	12	0	3	20	
	%	25.0	60.0	0.0	15.0	100	
Agriculture, teacher/Nepal Army/Police/Govt. Job/Pension	Count	31	23	0	1	55	
	%	56.4	41.8	0.0	1.8	100	
Other sources not including Agriculture (e.g. Job, foreign employment, Business, etc.)	Count	18	18	1	5	42	
	%	42.9	42.9	2.4	11.9	100	
Agriculture, Foreign employment (Gulf, Malaysia or equivalent)	Count	34	82	1	8	125	
	%	27.2	65.6	0.8	6.4	100	
Agriculture, Indian Army/police or Pension	Count	62	87	5	7	161	
	%	38.5	54.0	3.1	4.3	100	
Agriculture, Foreign Employment (Korea, Afghanistan, Iraq, Europe, America or equivalent)	Count	10	10	0	0	20	
	%	50.0	50.0	0.0	0.0	100	
Agriculture, British Army/Singapore Police or Pensioner	Count	3	4	0	0	7	
	%	42.9	57.1	0.0	0.0	100	
Total	Count	230	356	11	38	635	
	%	36.2	56.1	1.7	6.0	100	

Source: Field Survey, 2015.

The table 8.47 shows households having an income source as Agriculture with Business/ small Entrepreneurships (78.6%), Agriculture with labour or wage's works or Skill works (71.4%) were higher in percentage in giving vaccination for their children.

The Chi-Square (χ^2) test shows that there was a significant association ($\chi^2 = 53.509$, $df = 30$ and $p = .006$, which is less than .05) found between the respondents of different *income source of household* wise groups in their cultural practices on vaccination for children.

CHAPTER NINE

CHANGING ATTITUDES ON HEALTH AND MEDICATION PRACTICES

This section deals with the changes in the knowledge, attitude and practices about the ill-health and medication practices among the study population of the Magars. In the study, close-ended questionnaires were employed about the drinking water and sanitation, condition of toilet and uses, status of cooking oven, visiting health organization and doctors' patterns from the respondents, recognizing medicinal herbs and shrubs, food habits, knowledge about the communicable disease including HIV/AIDs and non-communicable disease, etc to the respondents for understanding changes in time duration. Frequency analysis was applied as descriptive statistics and gathered data of the study is compared with paired-samples t-test for analysis to get comparison significance.

9.1 Drinking Water, Toilet & Sanitation

Sanitation is the basic foundation for good health and prevention from several diseases. It is a public health issue. The French bacteriologist Louis Pasteur (1822-1895) discovered the 'Germ theory of disease' which gave miracle changes in public health (Park, 2005, p. 5) and fostered sanitation. The issues of proper management of sewage, proper supply of drinking water, avoidance of pollution and importance of sanitation raised in public and public health care. The subject of sanitation issues is found in every culture and society where they have own belief and practices about the sanitation based on their indigenous knowledge, their own awareness. In the study area, the people avoid defecation and urination surrounding water source for sanitation because they have a belief that it is a habitat of god (based on a conversation with key informants). Drinking water, toilets and practices are the basic things in sanitation.

9.1.1 Drinking Water Practice

Water is essential to living-beings for survival. Drinking water is the major health factor of human-being and has a great role in becoming healthy or falling into illness. Micro-organisms, minerals, and chemicals in water can affect human health. In Nepal, Cholera, Hepatitis-A and E, Diarrhoeal diseases and diseases transmitted through faeco-oral route spread epidemically every year and cause loss of lives. This situation can be prevented through clean drinking water and sanitation. Here, the changes in drinking water attitude and practices are presented in table 9.1:

Table 9.1: Changes in Drinking Water Practice

Response		10 Years Ago		After 10 Years		Changes			
		Frequency	%	Frequency	%	Frequency	%		
As like fetched/ Nothing done		595	93.6	412	64.8	-183	-28.8		
Using filter		17	2.7	63	9.9	46	7.2		
Using Chlorine/ Medicine		1	0.2	10	1.6	9	1.4		
By boiling		22	3.5	147	23.1	125	19.7		
Both filtering & boiling		1	0.2	4	0.6	3	0.5		
Total		636	100	636	100	-	-		
t- test									
Paired Samples Statistics						Paired Samples Correlations			
Drinking water Practices		Mean	N	Std. Deviation	Std. Error Mean	N	Correlation	Sig.	
Pair 1	After 10 Years	1.85	636	1.275	.051	636	.304	.000	
	10 years ago	1.14	636	.592	.023				
Paired Samples Test									
Drinking water Practices		Paired Differences				t	df	Sig. (2-tailed)	
		Mean	Std. Deviation	Std. Error Mean	95% Confidence Interval of the Difference				
					Lower				Upper
Pair1, After 10 Years - 10 Years ago	.709	1.232	.049	.805	.613	14.520	635	.000	

Source: Field Survey, 2015.

The table 9.1 shows, to control water-born diseases; the Magar community was not fully aware. It is found that 64.8% of respondents used drinking water as they fetched or nothing was done for drinking water which was 93.6% before 10 years ago. However, practices of using chlorine or medicine, filtering water, boiling, filtering and boiling respondents were found to be increased. It is because awareness in the community was increased due to media, education systems and health care systems.

The paired-samples t-test shows that there was a significant difference in the drinking water practices for before 10 years ($M=1.15$, $SD = 1.275$) and after 10 years ($M=1.85$, $SD= .593$) conditions; $t(14.520)$, $p=000$ (which is lower than $p=.05$).

9.1.2 Habits of Washing Hand before Taking Food

Proper washing hand before taking food have important role in health and illness. The hands could be contacted with many microbes in working and touching the objects. Such contamination could cause illness. The analysis and result of respondent's response changes towards hand washing habit, knowledge and practices are presented in table 9.2:

Table 9.2: Practice of hand Washing Habit before Taking Food

Response	Before 10 Years Ago		After 10 Years		Changes			
	Frequency	Percent	Frequency	Percent	Frequency	Percent		
Wash with plain water only	421	66.2	144	22.6	-277	-43.6		
Wash with water and ash	102	16.0	20	3.1	-82	-12.9		
Wash with water and soap	112	17.6	472	74.2	360	56.6		
Don't Know	1	0.2	0	0.0	-1	-0.2		
Total	636	100.0	636	100.0	-	-		
t- test (Paired Samples t-test)								
Paired Samples Statistics								
		Mean	N	Std. Deviation	Std. Error Mean			
Pair 1	After 10 Years	2.52	636	.839	.033			
	10 Years Ago	1.67	636	3.943	.156			
Paired Samples Test								
Response	Paired Differences				t	df	Sig. (2-tailed)	
	Mean	Std. Deviation	Std. Error Mean	95% Confidence Interval of the Difference				
				Lower				Upper
Pair 1, After 10 Years - 10 Years ago	.849	4.029	.160	.535	1.163	5.314	635	.000

Source: Field Survey, 2015.

The table 9.2 shows that, awareness of washing hands using soap and water before taking food was found increasing. Ten years ago, only 17.2% of respondents were aware to wash hands with soap and water which was increased to 74.2% in the present.

The paired-samples t-test shows that there was a significant difference in the washing hand before taking food habit and practices for before 10 years ($M=2.52$, $SD = .839$) and after 10 years ($M=1.67$, $SD= 3.943$) conditions; $t(5.314)$, $p=000$ (which is lower than $p=.05$).

9.1.3 Field Work and Sanitation

In the villages, peoples work in the field or farm. In working at farm or field work, they could be contacted with the soil and other contamination. After returning home from the field or somewhere, washing hands and feet or bathing helps in preventing contamination of the microbes before entering the kitchen for cooking. The analysis and result of changes in sanitation knowledge, awareness and attitudes of the respondents towards field work and sanitation are presented in table 9.3:

Table 9.3: Practices of Hand and Feet Washing for Sanitation after Returning from Farm or Field Work before Entering Kitchen.

Response	Before 10 Years		After 10 years		Changes	
	Frequency	Percent	Frequency	Percent	Frequency	Percent
Don't wash in hurry	145	22.8	51	8.0	-94	-14.8
Occasionally wash	129	20.3	48	7.5	-81	-12.7
Always wash	356	56.0	536	84.3	180	28.3
Don't know	6	0.9	1	0.2	-5	-0.8
Total	636	100	636	100		

Source: Field Survey, 2015

The table 9.3 shows, awareness and practice of washing hands and limbs for sanitation after working the field or somewhere was found to be increased dramatically from 28% to 84.3%, and they were doing regularly (always wash). However, do not wash in hurry, and occasionally washing respondents were significantly decreased. Further, 8% of respondents were found not washing in a hurry and 7.5% of respondents were found occasionally wash hands and limbs after returning from fieldwork or farm work. It indicates, there will be needed further awareness programs to change KAP of the respondents.

9.1.4 Hand Washing Practice after Using Toilet

To prevent from transmission of communicable diseases from the faeco-oral route, hand washing with soap and water after using a toilet is one of the simple methods. This could prevent a major portion of infections and infestations of germs and worms. The analysis and result of changing attitude and practices of respondents in hand washing with soap and water after using a toilet are presented in table 9.4:

Table 9.4: Hand Washing Practices after Using Toilet or Defecation/Urination

Response	Before 10 Years		After 10 Years		Changes	
	Frequency	Percent	Frequency	Percent	Frequency	Percent
Wash with water only	181	28.5	16	2.5	-165	-25.9
Wash with water and ash	191	30.0	24	3.8	-167	-26.3
Wash with water and soap	260	40.9	596	93.7	336	52.8
Don't Know	4	0.6	0	0.0	-4	-0.6
Total	636	100	636	100	-	-

Source: Field Survey, 2015.

The table 9.4 shows that, after using the toilet, washing hands with using water and soap practice and awareness was found increased by 52.8% from 40.9% in the past ten years. The practices of washing hands with plain water (water only), with water and ash are also decreased in recent years.

9.1.5 Having Toilet

The toilet is one of the basic necessary infrastructures in the keeping sanitation and prevention of communicable diseases. Both government and NGO/INGOs are investing to raise awareness about the construction and use of toilets for good health. Here, the analysis and result of changing patterns in having toilets in respondents' households are discussed. The situation of the toilets of the respondents is presented in Table 9.5:

Table 9.5: Situation of Toilets

Having Toilet		Before 10 Years		After 10 Years		Changes			
		Frequency	Percent	Frequency	Percent	Frequency	Percent		
Yes		465	73.1	622	97.8	157	24.7		
No		171	26.9	14	2.2	-157	-24.7		
Total		636	100	636	100				
t- test (Paired samples t-test)									
Paired Samples Statistics						Paired Samples Correlations			
Having Toilet		Mean	N	Std. Deviation	Std. Error Mean	N	Correlation	Sig.	
Pair 1	10 Years Ago	1.27	636	.444	.018	636	.199	.000	
	After 10 years	1.02	636	.147	.006				
Paired Samples Test									
Having Toilet		Paired Differences				t	df	Sig. (2-tailed)	
		Mean	Std. Deviation	Std. Error Mean	95% Confidence Interval of the Difference				
					Lower				Upper
Pair 1, 10 Years ago- After 10 Years		.247	.439	.017	.281	.213	14.189	635	.000

Source: Filed Survey, 2015

The table 9.5 shows that, in the study area, toilet construction in the respondents' households before 10 years was 73.1% having toilets and 26.9% had no toilets. In recent years, the percentage was changed and having toilet respondents were increased up to 97.8% from 2.2%. But, only 2.2% of households did not have toilets in the study period.

The paired-samples t-test shows that there was a significant difference in the having toilet in the respondent's house for before 10 years (M=1.27, SD = .444) and after 10 years (M=1.02, SD= .147) conditions; t (14.189), p=000 (which is lower than p=.05).

9.1.6 Types of Toilet

The infrastructure of the toilets shows the standard of sanitation and sustainability in using toilets in the community. Having better infrastructure helps to keep better sanitation. The infrastructures of the toilet are based on market availability, technology and socio-economic situation. Here, findings of types of toilets having in the respondents' house and changing patterns in infrastructures are discussed. The result of the survey is presented in table 9.6:

Table 9.6: Types of Toilets

Types of Toilet	Before 10 Years		After 10 years		Changes			
	Frequency	Percent	Frequency	Percent	Frequency	Percent		
Dug well/pit latrine	304	47.8	140	22.0	-164	-25.8		
Dug well/Pit latrine with slab	94	14.8	68	10.7	-26	-4.1		
Water sealed latrine with raw wall	34	5.3	162	25.5	128	20.1		
Modern latrine	35	5.5	252	39.6	217	34.1		
No Latrine	155	24.4	0.0	0.0	-155	-24.4		
Total	622	97.8	622	97.8	-	-		
* Missing System	*14	*2.2	*14	*2.2	-	-		
Total	636	100	636	100	-	-		
t- test (Paired samples t-test)								
Paired Samples Statistics								
		Mean	N	Std. Deviation	Std. Error Mean			
Pair 1	10 Years Ago	20.37	622	32.662	1.310			
	After 10 Years	2.85	622	1.180	.047			
Paired Samples Test								
Types of Toilet	Paired Differences					t	df	Sig. (2-tailed)
	Mean	Std. Deviation	Std. Error Mean	95% Confidence Interval of the Difference				
				Lower	Upper			
Pair1, 10 Years ago - After 10 years	17.523	32.699	1.311	14.948	20.097	13.365	621	.000

* Respondents having no toilets in their own house

Source: Field Survey, 2015

The table 9.6 shows that, the dug well/pit latrine having households decreased by 25.5% and squeezed into 22% from the 47.5%. The dug well/pit latrine with slab type was found decreased by 4.1% which was 14.8% before 10 years ago. The water-sealed latrines with the raw wall were found increased 20.1% from 5.3% before 10 years ago to recently 25.5%. Similarly, construction of modern latrine type increased by 34.1% and reached 5.5% 10 years ago to 39.6% in the study period. The interesting is 24.4% of respondents who had no toilet before 10 years constructed the toilet in their house.

The paired-samples t-test shows that there was a significant difference in the types of toilets in the respondent's house for before 10 years ($M=20.37$, $SD = 32.662$) and after 10 years ($M=2.85$, $SD= 1.180$) conditions; $t (13.365)$, $p=000$ (which is lower than $p=.05$).

9.1.7 Toilet Using Practice in House

Construction of the toilet and regular use of the toilet is essential to better sanitation and prevention of communicable diseases. Here, the changing pattern in using practice of the toilet in the study area based on information gathered from the respondent responses is analysed and discussed. And, the result of the survey is presented in table 9.7:

Table 9.7: Latrine/toilet Using Habit

Toilet Using Habit	Before 10 Years		After 10 years		Changes				
	Frequency	Percent	Frequency	Percent	Frequency	Percent			
Regularly used	406	63.8	594	93.4	188	29.6			
Mostly used	42	6.6	11	1.7	-31	-4.9			
Sometime used	23	3.6	12	1.9	-11	-1.7			
Difficulty due to water problem	2	0.3	4	0.6	2	0.3			
Do not use	149	23.4	1	0.2	-148	-23.3			
Total	622	97.8	622	97.8	-	-			
* Missing System	*14	*2.2	*14	*2.2	-	-			
Total	636	100	636	100	-	-			
t-test (Paired Samples t-test)									
Paired Samples Statistics					Paired Samples Correlations				
Toilet Using habits		Mean	N	Std. Deviation	Std. Error Mean	N	Correlation	Sig.	
Pair 1	10 Years ago	2.11	622	1.689	.068	622	.086	.032	
	After 10 Years	1.08	622	.415	.017				
Paired Samples Test									
Toilet Using habits		Paired Differences				t	df	Sig. (2-tailed)	
		Mean	Std. Deviation	Std. Error Mean	95% Confidence Interval of the Difference				
Lower	Upper								
Pair1, 10 Years Ago - After 10 Years		1.027	1.704	.068	.893	1.161	15.039	621	.000

* Respondents have no toilets in their own house

Source: Field Survey, 2015

The table 9.7 shows that, the regular use of toilets was found increased up to 93.4% from 63.8% and the difference was by 29.6%. Further, 23.3% of respondents decreased from those who did not use toilet groups. However, 0.2% of respondents have constructed toilets but they had not used the toilet. The 0.6% of respondents gave their opinion having water shortage/difficulties to use regular toilet in the house.

The paired-samples t-test shows, there was a significant difference in the regular using habits toilets in the respondent's house for before 10 years ($M=2.11$, $SD = 1.689$) and after 10 years ($M=1.08$, $SD= .415$) conditions; $t (15.039)$, $p=000$ (which is lower than $p=.05$).

9.1.8 Toilet Using Practice Outsides (Open Defecation)

In the villages, open defecation practices pollute water resources and can spread communicable diseases like typhoid, diarrhoea, cholera and so on faeco-oral route transmitted diseases. The open defecation could be in the field, path, herding animals because public toilets rarely found in the villages. Here, the changing pattern in the practice of open defecation and uses of toilets when they become away from the house by the respondents is discussed. And, the result is presented in table 9.8:

Table 9.8: Practice of Open Defecation when Working in Field or Travelling

Response		Before 10 years		After 10 years		Changes			
		Frequency	Percent	Frequency	Percent	Frequency	Percent		
Jungle/ravine, rivulet		526	82.7	145	22.8	-381	-59.9		
Ask to neighbour latrine		108	17.0	418	65.7	310	48.7		
Returned home for latrine		2	.3	73	11.5	71	11.2		
Total		636	100	636	100				
t-test (Paired Samples t-test)									
Paired Samples Statistics						Paired Samples Correlations			
Response		Mean	N	Std. Deviation	Std. Error Mean	N	Correlation	Sig.	
Pair 1	After 10 Years	1.89	636	.575	.023	636	.237	.000	
	10 Years ago	1.18	636	.389	.015				
Paired Samples Test									
Response		Paired Differences				t	df	Sig. (2-tailed)	
		Mean	Std. Deviation	Std. Error Mean	95% Confidence Interval of the Difference				
					Lower				Upper
Pair1; After 10 Years- 10 Years ago		.711	.613	.024	.663	.758	29.229	635	.000

Source: Field Survey, 2015.

The table 9.8 shows that, 82.7% of practice of open defecation when working in the field, animal herding, travelling or becoming away from the house is significantly reduced to 22.8% in 2015AD from 82.7%. Similarly, using toilet and searching neighbour toilets percentage increased into 48.7% and returning home was found 11.2%. However, public toilets are needed on the side of road or path, and public places to sustain the public practice of using toilets and reduced open defecation because 22.8% of respondents were found still doing open defecation when became out from the house.

The paired-samples t-test shows that there was a significant difference in the avoiding open defecation habits toilets when working in the field or away from the house for before 10 years (M=1.18, SD = .389) and after 10 years (M=1.89, SD= .575) conditions; t (29.229), p=000 (which is lower than p=.05).

9.2 Kitchen Hearth/Oven Facilities for Cooking

The facilities for cooking, the structure of kitchen and hearth/oven could be important to the household members for better health. Generally, in the villages, females are involved in cooking. Traditional firewood hearth produces more smoke which is inhaled by the cook and other members who live near to the kitchen or one-room house. The smoke could produce Chronic Obstructive Pulmonary Disease (COPD), Asthma and several respiratory diseases. Here, the type of infrastructures of the hearth/oven and changes in the respondent's household is discussed. And, the result is presented in table 9.9:

Table 9.9: Types of Hearth or Oven for Cooking

Type of hearth or Oven	Before 10 Years		After 10 Years		Changes	
	Frequency	%	Frequency	%	Frequency	%
Traditional firewood	584	91.8	298	46.9	-286.0	-45.0
Improved firewood oven	23	3.6	55	8.6	32.0	5.0
Bio-gas plant oven	3	.5	12	1.9	9.0	1.4
Traditional & LP gas oven	13	2.0	182	28.6	169.0	26.6
Traditional & Bio-gas	13	2.0	76	11.9	63.0	9.9
LP Gas Oven	0	0	8	1.3	8.0	1.3
Improved firewood oven, Bio-gas & LP gas	0	0	5	0.8	5.0	0.8
Total	636	100	636	100		

t-test (Paired Samples t-test)								
Paired Samples Statistics					Paired Samples Correlations			
Type of hearth or Oven		Mean	N	Std. Deviation	Std. Error Mean	N	Correlation	Sig.
Pair 1	After 10 Years	2.57	636	1.669	.066	636	.238	.000
	10 Years ago	1.19	636	.729	.029			

Paired Samples Test								
Type of Hearth or Oven	Paired Differences					t	df	Sig. (2-tailed)
	Mean	Std. Deviation	Std. Error Mean	95% Confidence Interval of the Difference				
				Lower	Upper			
Pair1; After 10 Years - 10 Year Ago	1.382	1.654	.066	1.253	1.511	21.067	635	.000

Source: Field Survey, 2015.

The table 9.9 shows that, the traditional hearths/ovens reduced by 45% from 91.8% before 10 years. The improved firewood oven, Bio-gas oven, LP gas ovens were found increased. This indicates increase of urbanization and the use of fire-wood is also decreasing. However, the main source of the fuel for cooking was found fire-wood, and adding LP gas as fuel for cooking altogether with firewood was found increasing.

The paired-samples t-test shows, there is significant difference in traditional fire-wood hearth and adding modern fuels for cooking of respondents' households for before 10 years ago

($M=1.18$, $SD = .389$) and after 10 years ($M=1.89$, $SD= .575$) conditions; $t (29.229)$, $p=000$ (which is lower than $p=.05$).

9.3 Health Seeking Behaviour

In Magar habituated land, medical pluralism is observed with the practices of traditional healers such as shaman, using medicinal herbs and shrubs, ayurvedic medicine, acupuncture service, astrologers or fortune tellers, priests, worshiping in shrines and bio-medicine. The publicity of bio-medicine (western medicine) is found all over the country. The government, media and market have invested more money in bio-medicine. The health-seeking behaviour of respondents is discussed here.

9.3.1 Bio-medicine

Bio-medicine (western medicine) is leading in health care services in the study area with a wide-range market. The peoples of the study area visit hospitals, pharmacies in their illness for healings. Here, the changing attitude and practices in visiting doctors or modern health institution is discussed and the result is presented in table 9.10:

Table 9.10: Visiting Trends towards Modern Health Institution or Doctor for Treatment

Response		Before 10 Years		After 10 Years		Changes			
		Frequency	%	Frequency	%	Freq.	%		
Not curing from worshipping/Promise to worship		349	54.9	106	16.7	-243	-38.21		
Not curing from the shaman		151	23.7	88	13.8	-63	-9.91		
Instantly when fall in ill		76	11.9	364	57.2	288	45.28		
In Emergency condition		20	3.1	52	8.2	32	5.03		
In serious/ chronic illness		37	5.8	23	3.6	-14	-2.20		
Don't Know		3	.5	3	.5	0	0.00		
Total		636	100	636	100				
t-test (Paired Samples t-test)									
Paired Samples Statistics						Paired Samples Correlations			
		Mean	N	Std. Deviation	Std. Error Mean	N	Correlation	Sig.	
Pair 1	After 10 Years	3.14	636	6.675	.265	636	.332	.000	
	10 Years ago	2.27	636	6.760	.268				
Paired Samples Test									
Response		Paired Differences				t	df	Sig. (2-tailed)	
		Mean	Std. Deviation	Std. Error Mean	95% Confidence Interval of the Difference				
					Lower				Upper
Pair 1; After 10 years - 10 Years ago		.869	7.766	.308	.265	1.474	2.824	635	.005

Source: Field Survey, 2015

The table 9.10 shows that, the practices of respondents in going to see a doctor or modern health institution instantly when they or family member fall into illness was found increased by 45.2%. The instantly visiting shaman in falling illness respondents is decreasing.

The paired-samples t-test shows that there is significant difference in visiting doctor or modern medical institution of respondents for before 10 years ($M=2.27$, $SD= 6.760$) and after 10 years) ($M=3.14$, $SD = 6.675$) conditions; $t(2.824)$, $p=005$ (which is lower than $p=.05$).

9.3.2 Visiting Traditional Healers

Traditional healers are also healers or health care providers within the study area. Before the introduction of bio-medicine, it was widely practiced. Here, changing attitude and practices of respondents in going to see traditional healer, faith healers when they fall in illness are discussed. And, the result is presented in table 9.11:

Table 9.11: Condition to Visiting Traditional Healers/Faith Healer for Treatment

Response	Before 10 Years		After 10 years		Changes	
	Frequency	%	Frequency	%	Freq.	%
Instantly when fall in ill	258	40.6	154	24.2	-104	-16.4
In minor illness also	174	27.4	129	20.3	-45	-7.1
Not curing by doctor or hospital' treatment	92	14.5	275	43.2	183	28.8
Suffering from chronic illness	40	6.3	35	5.5	-5	-0.8
when modern treatment became expensive	50	7.9	24	3.8	-26	-4.1
No, Go to Church	0	0.0	3	0.5	3	0.5
No Belief	1	0.2	5	0.8	4	0.6
Don't know	21	3.3	11	1.7	-10	-1.6
Total	636	100	636	100	-	-

Source: Field Survey, 2015

The table 9.11 shows that, the respondents who have visited the shaman or traditional healers in condition instantly when fall in ill found decreased by 16.4% from 40.6% and in minor illness by 7.1% from 27.4% in past 10 years respectively. The respondents who were suffered from chronic illness and felt modern medicine expensive from their socio-economic perspective were also found decreased in number. Not believing in traditional healing was also found increasing from 0.6%.

It is found that the respondents who firstly visited doctor or modern health institution and could not get well and were not cured from the bio-medicine, visited the traditional healers were increased by 28.8%. This indicates that the public is looking at traditional healing care as an alternative healing system in the hegemony era of bio-medicine. Furthermore, in

traditional healing practice, church-going respondents for healing were also found in the last 10 years which were not found before 10 years, and this indicates the influence of Christianity and churches are establishing new shrines in the Magar villages.

9.3.3 Knowledge of Herbal Medicine Practice

The use of medicinal plants, herbs and shrubs are indigenous knowledge system of the society and ethnic groups. Here, the changing pattern in attitude and knowledge about the medicinal herbs and shrubs, plants in the Magar society is discussed. And, the result of the survey is presented in table 9.12:

Table 9.12: Knowledge of Medicinal Herbs and Shrubs used by Magar Ancestors

Response	Before 10 Years		After 10 Years		Changes	
	Frequency	Percent	Frequency	Percent	Frequency	Percent
A lots of	43	6.8	27	4.2	-16	-2.5
Only 5-7 types	127	20.0	131	20.6	4	0.6
Only 2-4 types	267	42.0	298	46.9	31	4.9
Could not recognize	199	31.3	180	28.3	-19	-3.0
Total	636	100.0	636	100.0	-	-

Source: Field Survey, 2015

The table 9.12 shows that, the forgetting pattern of knowledge of medicinal herbs and shrubs, plants and their uses when fell into illness. The 6.8% of respondents were recognized plenty of medicinal herbs and shrubs before 10 years and 2.5% forgot in the last 10 years and shifted to few numbers. In Magar villages, 46.9% of respondents recognized 2-4 types of medicinal plants, herbs and shrubs. In contrast, 28.3% of respondents could not recognize any medicinal plants, herbs and shrub which are found locally, but 3% respondents had learned few medicinal plants, herbs and shrubs in last 10 years. This indicates that few respondents are trying to learn indigenous knowledge whereas losing indigenous knowledge rate and volume is highly increased in the Magars.

9.4 Changing in Food Habits

Food habit is essential to well-being and good health. Essential nutrition for human body is gained from food. Furthermore, a balanced diet or healthy food behaviours can maintain individual and community health. The indigenous peoples have their own food culture for survival and get essential nutrition. The local foods are generally based on their own production, indigenous practices, technology and availability in the market. Here, the changing attitude and practices of the traditional foods and modern junk food are discussed which was found in the Magar villages.

9.4.1 Use of Traditional Foods

The traditional foods are based on the agricultural production of the local area where Magars have settled. In the study area, there were main grains maize, millet, wheat, buckwheat, beans, and in low lands rice, different kinds of yams including *Gittha*, *Bhyakur*, arum, arum leaf, nettle, green vegetables, etc which were cultivated. However, in recent years cultivation and agricultural works are not in a priority and packaged food of market products are available in every Magar villages (based on the conversation with key informants, 2015). Here, changing pattern in consuming traditional foods which are considered as nutritious food from the perspective of Nutrition science. And the result of the survey is presented in table 9.13:

Table 9.13: Changing Pattern in Consuming Traditional Foods among the Magars

Response	Before 10 Years		After 10 years		Changes	
	Frequency	Percent	Frequency	Percent	Frequency	Percent
Regularly	290	45.6	29	4.6	-261	-41.0
Mostly/ Often	230	36.2	162	25.5	-68	-10.7
Occasionally/ Sometimes	110	17.3	424	66.7	314	49.4
Not taken	4	0.6	20	3.1	16	2.5
Don't Know	2	0.3	1	0.2	-1	-0.2
Total	636	100	636	100		

t-test (Paired Samples t-test)								
Paired Samples Statistics					Paired Samples Correlations			
Response		Mean	N	Std. Deviation	Std. Error Mean	N	Correlation	Sig.
Pair 1	After 10 Years	2.84	636	3.867	.153	636	.687	.000
	10 Years Ago	2.03	636	5.504	.218			

Paired Samples Test								
Response	Paired Differences					t	df	Sig. (2-tailed)
	Mean	Std. Deviation	Std. Error Mean	95% Confidence Interval of the Difference				
				Lower	Upper			
Pair 1; After 10 Years - 10 Years ago	.802	4.002	.159	.490	1.113	5.053	635	.000

Source: Field Survey, 2015.

The table 9.13 shows that the regular consumers of traditional and local foods were decreased by 41% and mostly/often or frequently consumer respondents decreased by 10.7% and occasionally user respondents increased by 49.4% and not consuming respondents increased by 2.5%. This indicates, the food habits of the Magars are changing condition and depending on the market and traditional corns and dishes are in shadow.

The paired-samples t-test shows that there was a significant difference in the traditional food consuming pattern of respondents for before 10 years ($M=2.03$, $SD = 5.504$) and after 10 years ($M=2.84$, $SD= 3.867$) conditions; $t(5.053)$, $p=000$ (which is lower than $p=.05$).

9.4.2 Junk Food Habit

The modern market is expanded into Magar villages and junk foods such as packed foods, instant noodles, biscuit/cookies, potato chips, chocolate, drinking beverages such as Pepsi/ coco-cola/ Redbull and so on are easily available in the villages. The traditional custom of giving milk, yogurt, *mahi (mohi)* in respecting guests is disappearing. Here, the changing attitude and practices in consuming junk food among the Magars are discussed and the result of the survey is presented in table 9.14:

Table 9.14: Pattern of Using Junk Food Habit among Magars

Response		Before 10 Years		After 10 years		Changes			
		Frequency	Percent	Frequency	Percent	Frequency	Percent		
Mostly/Often		26	4.1	57	9.0	31	4.9		
Sometimes/Occasionally		282	44.3	395	62.1	113	17.8		
Least/ very few		241	37.9	176	27.7	-65	-10.2		
Don't know/unknown		87	13.7	8	1.3	-79	-12.4		
Total		636	100	636	100				
t-test (Paired Samples t-test)									
Paired Samples Statistics						Paired Samples Correlations			
Response		Mean	N	Std. Deviation	Std. Error Mean	N	Correlation	Sig.	
Pair 1	10 Years ago	15.61	636	33.228	1.318	636	.212	.000	
	After 10 Years	3.41	636	10.813	.429				
Paired Samples Test									
Response		Paired Differences				t	df	Sig. (2-tailed)	
		Mean	Std. Deviation	Std. Error Mean	95% Confidence Interval of the Difference				
Lower	Upper								
Pair 1; 10 Years ago - After 10 Years		12.200	32.694	1.296	9.654	14.745	9.411	635	.000

Source: Field Survey, 2015.

The table 9.14 shows that frequently (mostly) consuming junk food in their household respondents were found 9% which was increased by 4.9%. The occasionally consuming households were found increased by 17.8% and reached 62.1% in the Magar village. Only 13.7% of respondents were unknown before 10 years which was reduced by 12.4%. This indicates the influence of junk food in Magar villages is increasing and advertisement, market are attracting them to use junk food, however, they do not know the nutritional values about the Junk food and proper uses.

The paired-samples t-test shows that there was a significant difference in the pattern of consuming junk food in Magar villages for before 10 years ($M=15.61$, $SD = 33.228$) and after 10 years ($M=3.41$, $SD= 10.813$) conditions; $t(9.411)$, $p=000$ (which is lower than $p=.05$).

9.5 Communicable and Non-communicable Diseases

Knowledge of communicable and non-communicable diseases helps in the prevention of diseases in the community and individuals. Communicable diseases can be transmitted from one individual to another or animal to human from various routes such as faeco-oral route, droplet route, by contact route, and so on which can prevent by doing intervention of the transmission route. In contrast, non-communicable diseases do not transfer from one person to another. Here, the changes in knowledge of respondents about the differences between communicable and non-communicable disease are discussed and the result of the survey is presented in table 9.15:

Table 9.15: Knowledge about Communicable and Non-communicable Illness

Response		Before 5 Year		After 5 years		Changes			
		Frequency	Percent	Frequency	Percent	Frequency	Percent		
Known		134	21.1	282	44.3	148	23.3		
Heard only		293	46.1	248	39.0	-45	-7.1		
Unknown		209	32.9	106	16.7	-103	-16.2		
Total		636	100	636	100				
t-test (Paired Samples t-test)									
Paired Samples Statistics						Paired Samples Correlations			
Response		Mean	N	Std. Deviation	Std. Error Mean	N	Correlation	Sig.	
Pair 1	5 years Ago	97.45	636	1.152	.046	636	.711	.000	
	After 5 years	96.89	636	1.049	.042				
Paired Samples Test									
Response		Paired Differences				t	df	Sig. (2-tailed)	
		Mean	Std. Deviation	Std. Error Mean	95% Confidence Interval of the Difference				
					Lower				Upper
Pair 1; 5 Years ago - After 5 Years		.557	.843	.033	.491	.622	16.657	635	.000

Source: Field Survey, 2015.

The table 9.15 shows that 23.3% of respondents in knowing the difference between communicable and non-communicable illnesses were increased and reached 44.3%. The unknown respondents about the communicable and non-communicable diseases were decreased by 16.2% and remained at 16.7%. This indicates awareness about communicable and non-communicable diseases is increasing; however, 16.7% of Magars were unknown

about the communicable and non-communicable diseases and needed awareness programs to change KAP for all populations.

The paired-samples t-test shows that there was a significant difference in knowledge about the difference between communicable and non-communicable diseases among the Magar villages for before 5 years (M=97.45, SD = 1.152) and after 5 years (M=96.89, SD= 1.049) conditions; $t(16.657)$, $p=000$ (which is lower than $p=.05$).

9.6 Knowledge about the Communicable Diseases

9.6.1 Knowledge about Animal Transmitted (Zoonotic) Diseases

Some communicable diseases are transmitted through the animals, birds, etc such as Bird-flue, Swine-flue, Rabies, plague and so on. The changes of knowledge and awareness about zoonosis (communicable illness transmitted through animals) are discussed here and the results are presented in table 9.16:

Table 9.16: Knowledge about Diseases Transmitted from the Bird and Animals

Response	Before 5 Years		After 5 Years		Changes				
	Frequency	Percent	Frequency	Percent	Frequency	Percent			
Known	100	15.7	212	33.3	112	17.6			
Heard only	291	45.8	327	51.4	36	5.7			
Unknown	245	38.5	97	15.3	-148	-23.3			
Total	636	100	636	100					
t-test (Paired Samples t-test)									
Paired Samples Statistics					Paired Samples Correlations				
Response		Mean	N	Std. Deviation	Std. Error Mean	N	Correlation	Sig.	
Pair 1	5 years ago	97.61	636	1.151	.046	636	.607	.000	
	After 5 years	96.97	636	.972	.039				
Paired Samples Test									
Response		Paired Differences				t	df	Sig. (2-tailed)	
		Mean	Std. Deviation	Std. Error Mean	95% Confidence Interval of the Difference				
					Lower				Upper
Pair 1; 5 Years ago - After 5 years		.642	.954	.038	.567	.716	16.953	635	.000

Source: Field Survey, 2015

The table 9.16 shows that illness transmitted through animals and birds, known respondents were increased by 17.6% and reached 33.3% and the only heard about the disease respondents were 5.7% and reached 51.4% in the survey period. The respondents unknown of zoonotic disease were decreased by 23.4 and remained 15.3%.

The paired-samples t-test shows, there was a significant difference in knowledge about the difference between communicable and non-communicable diseases among the Magar villages for before 5 years ($M=97.61$, $SD = 1.151$) and after 5 years ($M=96.97$, $SD= .972$) conditions; $t(16.953)$, $p=000$ (which is lower than $p=.05$).

9.6.2 Knowledge about HIV/AIDS

HIV/AIDS is a burning issue of public health and having concern of the world. HIV/AIDS is transmitted through the contact of serum and blood (especially, from sexual intercourse, blood and other body fluids) from one person to another. The change in attitude and knowledge about the HIV/AIDS is discussed here and the results are presented in table 9.17:

Table 9.17: Knowledge about Communicable Disease HIV/AIDS

Response	Before 5 Years		After 5 Years		Changes				
	Frequency	Percent	Frequency	Percent	Frequency	Percent			
known	432	67.9	502	78.9	70	11.0			
Unknown	204	32.1	134	21.1	-70	-11.0			
Total	636	100	636	100					
t-test (Paired Samples t-test)									
Paired Samples Statistics					Paired Samples Correlations				
Response		Mean	N	Std. Deviation	Std. Error Mean	N	Correlation	Sig.	
Pair 1	Before 5 Years ago	96.96	636	1.401	.056	636	.752	.000	
	After 5 Years	96.63	636	1.224	.049				
Paired Samples Test									
Response		Paired Differences				t	df	Sig. (2-tailed)	
		Mean	Std. Deviation	Std. Error Mean	95% Confidence Interval of the Difference				
					Lower				Upper
Pair1; 5 Years ago- After 5 Years	.330	.940	.037	.257	.403	8.862	635	.000	

Source: Field Survey, 2015

The table 9.17 shows that the number of known respondents about the HIV/AIDS was increased by 11% from 67.9% in the last 5 years. The unknown respondents about HIV/AIDS remained 21.1% in the Magar society. This indicates in the Magar villages; the people were not fully aware and knowledgeable about HIV/AIDS.

The paired-samples t-test shows that there was a significant difference in knowledge about HIV/AIDS among the Magar villages for before 5 years ($M=96.96$, $SD = 1.401$) and after 5 years ($M=96.63$, $SD= 1.224$) conditions; $t(8.862)$, $p=000$ (which is lower than $p=.05$).

9.7 Knowledge about the Non-communicable Diseases

9.7.1 Knowledge about Cancer Illness

Cancer is a non-communicable disease; currently, it is a burning issue of public health even in Nepal. And, the treatment cost of cancer is very expensive. The cause of Cancer is mostly unknown, however, lifestyle, food habits, smoking, alcohol, pollution, personal behaviours, radiation, chemicals, viruses, fungus, bacteria, environmental pollution and so on can be responsible to cause cancer. Here, changing attitude in knowledge about the Cancer illness is discussed and the result is presented in table 9.18:

Table 9.18: Knowledge about Cancer Illness

Response	Before 5 Years		After 5 Years		Changes				
	Frequency	Percent	Frequency	Percent	Frequency	Percent			
Known	162	25.5	243	38.2	81	12.7			
Heard only	311	48.9	338	53.1	27	4.2			
Unknown	163	25.6	55	8.6	-108	-17.0			
Total	636	100	636	100					
t-test (Paired Samples t-test)									
Paired Samples Statistics						Paired Samples Correlations			
Response		Mean	N	Std. Deviation	Std. Error Mean	N	Correlation	Sig.	
Pair 1	5 years ago	97.26	636	1.102	.044	636	.661	.000	
	After 5 years	96.79	636	.828	.033				
Paired Samples Test									
Response		Paired Differences				t	df	Sig. (2-tailed)	
		Mean	Std. Deviation	Std. Error Mean	95% Confidence Interval of the Difference				
Lower	Upper								
Pair 1; 5 Years Ago - After 5 Years		.467	.833	.033	.402	.532	14.143	635	.000

Source: Field Survey, 2015

The table 9.18 shows, that cancer disease known respondents found increased by 12.7% from 25.5%. Heard only respondents about the cancer disease found increased by 4.2% from 48.9%. Still, 8.6% of respondents were found unknown about the cancer diseases.

The paired-samples t-test shows that there was a significant difference in knowledge about Cancer diseases among the Magar villages for before 5 years (M=97.26, SD = 1.102) and after 5 years (M=96.79, SD=.833) conditions; t (14.143), p=000 (which is lower than p=.05).

9.7.2 Knowledge about Hypertension and Heart Diseases

Hypertension (High blood pressure) and heart diseases are increasing in the country. Changing lifestyle, sedentary lifestyle, changes in food consumption, lack of exercise, excessive mental stress, environmental hazards and pollution, pesticides and chemicals, smoking, and consumption of alcohol factors are responsible to increase hypertension and heart diseases. Here, changes of attitudes in knowledge and awareness about Hypertension and Heart diseases are discussed and the result of the survey is presented in table 9.19:

Table 9.19: Knowledge about Hypertension (high blood pressure) and Heart Diseases

Response	Before 5 Years		After 5 Years		Changes				
	Frequency	Percent	Frequency	Percent	Frequency	Percent			
Known	177	27.8	270	42.5	93	14.6			
Heard only	306	48.1	306	48.1	0	0.0			
Unknown	153	24.1	60	9.4	-93	-14.6			
Total	636	100	636	100					
t-test (Paired Samples t-test)									
Paired Samples Statistics					Paired Samples Correlations				
Response		Mean	N	Std. Deviation	Std. Error Mean	N	Correlation	Sig.	
Pair 1	Before 5 Years ago	97.20	636	1.096	.043	636	.660	.000	
	After 5 Years	96.76	636	.865	.034				
Paired Samples Test									
Response		Paired Differences				t	df	Sig. (2-tailed)	
		Mean	Std. Deviation	Std. Error Mean	95% Confidence Interval of the Difference				
Lower	Upper								
Pair 1; 5 Years Ago - After 5 years		.439	.835	.033	.374	.504	13.251	635	.000

Source: Field Survey, 2015

The table 9.19: shows that having knowledge about Hypertension and Heart diseases respondents were increased by 14.6% in the last 5 years and reached 42.5%. And not knowing about Hypertension and heart disease respondents were decreased by 14.6% and the majority of respondents found that they have heard about Hypertension and Heart diseases.

The paired-samples t-test shows that there was a significant difference in knowledge about Hypertension and heart diseases among the respondents for before 5 years (M=97.20, SD = 1.096) and after 5 years (M=96.76, SD= .865) conditions; t (13.251), p=000 (which is lower than p=.05).

9.7.3 Knowledge about Diabetes Mellitus

Diabetes Mellitus, generally people understand it as Sugar disease and chronic. This disease is increasing in Nepal and becoming an issue of public health problems. Urbanization and changes in lifestyle, food habits, lack of exercise, stress, sedentary life, environmental hazards and pollution, pesticides and chemicals, unnecessary use of drugs, alcohol, smoking, etc factors also helping to increase this disease in Nepal. Here, the changing attitude in knowledge about diabetes mellitus is discussed and the result is presented in table 9.20:

Table 9.20: Knowledge of Diabetes Mellitus

Response	Before 5 Years		After 5 years		Changes				
	Frequency	Percent	Frequency	Percent	Frequency	Percent			
Known	165	25.9	259	40.7	94	14.8			
Heard only	318	50.0	336	52.8	18	2.8			
Unknown	153	24.1	41	6.4	-112	-17.6			
Total	636	100.0	636	100.0					
t-test (Paired Samples t-test)									
Paired Samples Statistics					Paired Samples Correlations				
Response		Mean	N	Std. Deviation	Std. Error Mean	N	Correlation	Sig.	
Pair 1	Before 5 Years ago	97.22	636	1.084	.043	636	.603	.000	
	After 5 years	96.72	636	.767	.030				
Paired Samples Test									
Response		Paired Differences				t	df	Sig. (2-tailed)	
		Mean	Std. Deviation	Std. Error Mean	95% Confidence Interval of the Difference				
					Lower				Upper
Pair 1; 5 Year ago - After 5 Years	.500	.872	.035	.432	.568	14.458	635	.000	

Source: Field Survey, 2015.

The table 9.20 shows that in last 5 years 15.8% of respondents were increased in known category of the respondents and reached up to 40.7%. The unknown category of the respondents regarding diabetes mellitus was decreased by 17.6% and remained at 6.4%. The heard category respondents were increased by 2.8% and reached 52.8%. This indicates the awareness about diabetes mellitus is increasing in the Magar society and the majority of respondents have just heard about diabetes-mellitus diseases.

The paired-samples t-test shows that there was a significant difference in knowledge about diabetes mellitus among the respondents for before 5 years ($M=97.22$, $SD = 1.084$) and after 5 years ($M=96.72$, $SD= .767$) conditions; $t(14.458)$, $p=000$ (which is lower than $p=.05$).

9.7.4 Knowledge about Chronic Kidney Failure Disease (CKD)

Chronic Kidney Failure (CKD) is increasing in Nepal. It is costly in treatment which causes a difficult situation to pay. Regular dialysis, kidney transplant can save the life which is very much expensive. If the patient does not have enough money, then this disease is life-threatening. Increasing pesticides and chemicals in foods, unnecessary use of pain killer (NSAID) drugs and other medicines, habits of drinking less water, diarrhoeal diseases, excessive water loss from the body, environmental hazards and pollution, etc are hiking the rate of Chronic Kidney Failure Disease (CKD) illness in the community. The change in attitudes and knowledge about the Chronic Kidney Failure Disease (CKD) of respondents is discussed here and the result of the survey is presented in table 9.21:

Table 9.21: Knowledge towards Chronic Kidney Failure Disease (CKD)

Response	Before 5 Years		After 5 years		Changes				
	Frequency	Percent	Frequency	Percent	Frequency	Percent			
Known	135	21.2	208	32.7	73	11.5			
Heard only	282	44.3	314	49.4	32	5.0			
Unknown	219	34.4	114	17.9	-105	-16.5			
Total	636	100	636	100					
t-test (Paired Samples t-test)									
Paired Samples Statistics					Paired Samples Correlations				
Response		Mean	N	Std. Deviation	Std. Error Mean	N	Correlation	Sig.	
Pair 1	Before 5 Years ago	97.48	636	1.168	.046	636	.710	.000	
	After 5 Years	97.03	636	1.022	.041				
Paired Samples Test									
Response		Paired Differences				t	Df	Sig. (2-tailed)	
		Mean	Std. Deviation	Std. Error Mean	95% Confidence Interval of the Difference				
					Lower				Upper
Pair 1; 5 Year ago - After 5 Years	.445	.845	.033	.379	.511	13.285	635	.000	

Source: Field Survey, 2015

The table 9.21 shows, the known category respondents were increased by 11.5% and reached 32.7% from 21.2% in five years duration. The respondents who did not have knowledge of Chronic Kidney Failure (CKD) were decreased by 16.5% and remained at 17.9% from 34.4% before 5 years. However, the majority of respondents had heard about the diseases and have not more clear knowledge about the disease.

The paired-samples t-test shows that there was a significant difference in knowledge about chronic kidney failure (CKD) diseases among the respondents for before 5 years ago (M=97.48, SD = 1.168) and after 5 years (M=97.03, SD= 1.022) conditions; t (13.285), p=000 (which is lower than p=.05).

9.8 Family Planning and Reproductive Health

Issues of reproductive health and family planning have always become important subjects in public health and social health. GOs, NGOs and INGOs promoting health care, family planning and reproductive health in the community as well as in rural areas. Here, knowledge about family planning and reproductive health is tried to understand by the Magars of Syangja district.

9.8.1 Knowledge about the Family Planning Methods

Knowledge about family planning methods is important to better reproductive health. Family planning gives knowledge about the methods for birth spacing, sexually transmitted disease, sex education, child-rearing and caring, women's health, men's health, etc and available health care facilities about the surrounding. In Nepal, several kinds of family planning methods are available such as permanent method, temporary method, emergency contraceptive, etc. The changes in attitude and knowledge about family planning among the Magars are discussed here, and the result of the survey is presented in table 9.22:

Table 9.22: Knowledge about Family Planning Methods

Response		Before 5 Years		After 5 Years		Changes			
		Frequency	Percent	Frequency	Percent	Frequency	Percent		
Known		287	45.1	384	60.4	97	15.3		
Heard only		195	30.7	160	25.2	-35	-5.5		
Unknown		154	24.2	92	14.5	-62	-9.7		
Total		636	100	636	100	-	-		
t-test (Paired Samples t-test)									
Paired Samples Statistics						Paired Samples Correlations			
Response		Mean	N	Std. Deviation	Std. Error Mean	N	Correlation	Sig.	
Pair 1	Before 5 years ago	97.03	636	1.192	.047	636	.743	.000	
	After 5 years	96.69	636	1.042	.041				
Paired Samples Test									
Response		Paired Differences				t	df	Sig. (2-tailed)	
		Mean	Std. Deviation	Std. Error Mean	95% Confidence Interval of the Difference				
					Lower				Upper
Pair 1; 5 Years ago- After 5 Years	.347	.813	.032	.284	.411	10.773	635	.000	

Source: Field Survey 2015

The table 9.22 shows that in the last 5 years, the family planning methods known respondents were increased by 15.3% and reached 60.4%. The respondents who did not have knowledge about family planning methods were decreased by 9.7% and remained 14.5%.

The paired-samples t-test shows that there was a significant difference in knowledge about family planning methods among the respondents for before 5 years ($M=97.03$, $SD = 1.192$) and after 5 years ($M=96.69$, $SD= 1.042$) conditions; $t(10.773)$, $p=000$ (which is lower than $p=.05$).

9.8.2 Knowledge on Unwanted Pregnancy and Abortion Right

Nepalese constitution, legislations and acts on reproductive health are ensuring the rights to abortion for women who have unwanted pregnancy before 12 weeks of pregnancy in normal condition, and 18 weeks of pregnancy due to becoming a victim of rape and sexual intercourse of kindred within forbidden degrees of relations. The changes in attitudes and knowledge about unwanted pregnancy and abortion rights among the Magars are discussed here, and the result is presented in table 9.23:

Table 9.23: Knowledge about Unwanted Pregnancy and Abortion Rights

Response	Before 5 Years		After 5 years		Changes				
	Frequency	Percent	Frequency	Percent	Frequency	Percent			
Known	80	12.6	179	28.1	99	15.6			
Heard only	252	39.6	265	41.7	13	2.0			
Unknown	304	47.8	192	30.2	-112	-17.6			
Total	636	100	636	100					
t-test (Paired Samples t-test)									
Paired Samples Statistics					Paired Samples Correlations				
Response		Mean	N	Std. Deviation	Std. Error Mean	N	Correlation	Sig.	
Pair 1	Before 5 years ago	97.83	636	1.162	.046	636	.720	.000	
	After 5 years ago	97.32	636	1.178	.047				
Paired Samples Test									
Response		Paired Differences				t	df	Sig. (2-tailed)	
		Mean	Std. Deviation	Std. Error Mean	95% Confidence Interval of the Difference				
					Lower				Upper
Pair 1; 5 Years Ago - After 5 Years	.508	.876	.035	.440	.576	14.626	635	.000	

Source: Field Survey, 2015.

The table 9.23 shows that the respondents having knowledge about unwanted pregnancy and abortion rights were increased by 15.6% from 12.6% and reached 28.8%. The respondents who did not have knowledge about unwanted pregnancy and abortion rights were decreased by 17.6% from 47.8% in five years. This indicates the majority of Magars were not fully

aware of unwanted pregnancy and abortion rights of the study area, however, the knowledge has been in changing direction.

The paired-samples t-test shows that there was a significant difference in knowledge about unwanted pregnancy and abortion right among the respondents for before 5 years ($M=97.83$, $SD = 1.162$) and after 5 years ($M=97.32$, $SD= 1.178$) conditions; $t (14.626)$, $p=000$ (which is lower than $p=.05$).

9.8.3 Pregnancy and Antenatal Check-up Practices

The pregnancy and regular antenatal check can be prevented complications in the delivery period. Regular check-ups in pregnancy conditions from qualified and experienced doctors or health workers can diagnose incoming complications and safe delivery in the future. In sub-health posts and Government health institutions, antenatal clinics are arranged to improve the health of mother and child and provide them awareness to go to health institutions to visit antenatal clinics at least four or more times in the gestation period. The changing knowledge and attitudes in regular antenatal check-ups in pregnancy are discussed, and the result of the survey is presented in table 9.24:

Table 9.24: Knowledge about Antenatal Check-ups

Response		Before 5 Years		After 5 years		Changes			
		Frequency	Percent	Frequency	Percent	Frequency	Percent		
At least four times		166	26.1	241	37.9	75	11.8		
At least three times		61	9.6	62	9.7	1	0.2		
At least two times		30	4.7	17	2.7	-13	-2.0		
As need/necessary		160	25.2	150	23.6	-10	-1.6		
Don't know		219	34.4	166	26.1	-53	-8.3		
Total		636	100.0	636	100.0				
t-test (Paired Samples t-test)									
Paired Samples Statistics						Paired Samples Correlations			
		Mean	N	Std. Deviation	Std. Error Mean	N	Correlation	Sig.	
Pair 1	Before 5 years ago	35.69	636	45.929	1.821	636	.731	.000	
	After 5 years	27.44	636	42.579	1.688				
Paired Samples Test									
Response		Paired Differences				t	df	Sig. (2-tailed)	
		Mean	Std. Deviation	Std. Error Mean	95% Confidence Interval of the Difference				
					Lower				Upper
Pair 1; 5 Years ago - After 5 years		8.253	32.601	1.293	5.715	10.792	6.384	635	.000

Source: Field Survey, 2015.

The table 9.24 shows that the respondents having the knowledge to visit health institution for an antenatal check-up in pregnancy at least four times or regular check-ups increased by

11.8% from 26.1% and respondents who were unknown about the antenatal check were reduced by 8.3%. The table indicates that clear knowledge about the antenatal check-ups of respondents is in a weak position, however, the level of awareness and knowledge is increasing in the Magar community.

The paired-samples t-test shows that there was a significant difference in knowledge about antenatal check-up during pregnancy among the respondents for before 5 years ($M=35.69$, $SD = 45.929$) and after 5 years ($M=27.44$, $SD= 42.579$) conditions; $t (6.384)$, $p=000$ (which is lower than $p=.05$).

CHAPTER TEN

SUMMARY AND CONCLUSION

10.1 Summary

This study is focused on the Magar's perception on health, illness and medication practices in their socio-cultural background of Syangja district in Nepal. The Magars belong to an ethnic group among the 125 ethnic/caste groups of Nepal, and they cover the third largest population (CBS 2011). They are indigenous peoples (GoN-NFDIN, 2063BS) of ancient Magarat (Sapta-Gandaki, Rapati and Bheri Rivers basins) of Nepal. The main habitats of Magars are surrounding of Gandaki River or west of Trisuli River and to the east of Karnali River (BaralMagar 2050BS; Sharma, 2067 BS; Bista, 2004; Hitchcock, 1966; Regmi 1961), however, they are found scattered all over the country. They played great roles during the period of unification of Nepal, a significant presence on revolution and political movements to the peace process and contribution in the nation-building process as well as development and prosperity of Nepal. The Magars have a distinct culture, language and ways of living. This study combines the socio-cultural aspects of those Magars and their perceptions on health, illness and medication practices which was almost an unexplored subject in the surroundings of Tamkikot hill of Syangja district. Some studies have been already carried out about the Magars, and health in social science and public health. However, those studies focused less on the local perception in health, illness and medication practices among the Magars.

The earlier western scholars Kirkpatrick (1811), Hamilton (1818), Oldfield (1880), Wright (1877), Vansittart (1906) pointed out few aspects of Nepalese illness, healing traditions, health care practices and described the Magars as a warrior tribal group. Vansittart (1906), Landon (1928), Northey (1937) had given an emphasis on military tribe and warrior characteristics. However, Caplan (1995 reprint 2009) argued that there have socio-political, economic reasons to become warrior gentlemen. Hitchcock (1966) found that worship of god, goddess and godlings (local god/goddess) mainly for healing, prevention from illness and misfortune among the Magars of Banyan hill. Watters (1975) described shamanism culture and healings of the Magars of Rukum. Similarly, Oppitz (1983) has explored the origin myth of Magars of Rukum based on shamanism from the ethnographic study. Oppitz (1982) has also described from a structural-functionalism perspective about the kinship system in marriage and death rituals. Molnar (1981) has described socio-economic livelihood of

the Magars who are settling in Thawang, Luwang, Taka and Maikot from an ecological perspective. Fisher (1986) illustrated the Northern Magars of Dolpa district and their culture, rituals, way of living, relations and changes from the world system and transactional approach. Kawakita Jiro (1974) pointed out shamanism, worship for healing and prevention from illness and misfortune in the culture of Magars of Myagdi district. Similarly, Shepherd (1982) pointed out shamanism, worship several god and goddess for healing, and prevention from illness and misfortune among the Magars of Yangchok Tanahu district and Arkhala of Nawalparasi districts.

Further, Kristvik (1999) described traditional beliefs of relevance to the symptom of Tuberculosis (TB), health beliefs, and health care practice of Bhojpur district in Nepal, and Gartoulla (1998) has described ill-health and medication from the perspective of ethnomedicine and therapy perspective and also illustrated uses of medicinal plants. In such a way, Budhathoki (2011) has described ill-health perception and medication practices regarding febrile conditions and malaria. Similarly, Harper (2014) illustrated causation of ill-health, lama (shamanism), medical pluralism and medication practices and public health care services of Palpa district of Nepal. Baralmagar (2050BS) has studied the Magar culture of the Palpa, Tanahu and Syangja Districts. Bista (1967 reprint 2011) has described Magar's socio-culture and livelihood. Similarly, Sharma (2067 BS), Subedi (2063 BS), Shiwakoti (2074 BS), Thapamagar (2059 BS), Thapa (2067 BS), Thapamagar (2063 BS), Ghartimagar (2053 BS), Ghartimagar (2071 BS), Gurung (1980), Gurung (2067), Rai (2064 BS) and others also mentioned about the Magars; but they have not mentioned about the aspect of ill-health and medication of the Magars. Similarly, Dhakal (1996) discussed the traditional institution 'Bheja' of Magars. Magar (2009) described indigenous knowledge about the collection of local medicinal herbs, and Magar (2013) points out the construction of identity from the modern organizations of Magars, which are not cover the topics of ill-health and medication among the Magars.

Furthermore, Hamilton (1819) did fieldwork in 1803-4 AD in Nepal and mentioned little bit health status of contemporary Nepal. Similarly, medical doctor, Oldfield (1880) also was mentioned the health status during the period of Janga Bahadur Rana. After the 1950s, earlier works are concentrated on shamanism, ethnic shamanism and traditional healings. Such as Hitchcock (1967), Hitchcock and Jones (1976), Hitchcock (1976), Jones (1976), Watters (1975), Maskarinec (2000), Desjarlais (1992), Sagant (1996), Miller (1997), etc. researchers contributed in shamanism, traditional healing, faith healings, spiritual dimensions and medical sociology/ anthropology. Vincanne Adams (1998), Ellen Kristvik, (1999), Ian Harper

(2014), Padam Lal Devkota (1984), Janardan Subedi (1989), Ritu Prasad Gartoulla (1998 & 2008), Madhusudan Sharma Subedi, (2001, 2003 & 2011), Kapil Babu Dahal (2007) and some others have contributed in Nepalese medical sociology and medical anthropology. Furthermore, Chand and Upreti (2013) have prepared a bibliography of 'Medical Anthropological/Sociological Studies in Nepal. In contrast, such studies do not explore the local perception of ill-health and medication practices of the Magars.

10.1.1 Selection of Area and Sampling

The researcher conducted this research from the social constructive world view in structural-functional approach, with quantitative and qualitative (mixed) research design. The researcher has selected the study area and ethnic group applying the multistage sampling method. First of all, the researcher chose Nepal, then Syangja district and Magar. Finally, he limited it in the surrounding Tamkikot hill. There were four reasons behind selecting the study area and ethnic group: i) research questions of the study and variable relationship fitted in the area; ii) the Magars are indigenous people of Nepal having the third largest population and scattered all over Nepal (CBS 2011), and they have a great role in the construction and prosperity of Nepal; iii) the selected study area is a historical place of the Magars; iv) the Magars of the study area speak Magar language as their mother tongue. Therefore, the researcher selected Magars of surrounding Tamkikot hill of Syangja district of Nepal.

First of all, probability sampling was used to select respondents for the household survey. There were 4,243 household Magars in the study area and 636 (or 15%) households were selected for the study through random sampling giving equal weight for every VDCs to know local perception on ill-health and medication practices. In second, the key informants were selected through a purposive sample from every VDC who were senior people, social workers having local knowledge and Magars. In the third stage, the researcher participated in group discussion and interview schedules; and observations were administrated in some ritual and cultural performances for the research. Fourth, the researcher met respondents for verifying the collected information and data. After this, since the research being connected to social science, ethical approval was taken from "Ethical board" of the "Nepal Health Research Council (NHRC)" of Nepal, Ministry of Health and Population dated on 26 July 2015 as Reg. No. 47. Finally, the researcher usually had taken field notes, captured photographs, recorded voice records of the key informants', their interviews and group discussions.

10.1.2 The Detail Analysis and Findings

The researcher found that the perception of ill-health and medication practices among the Magars is significantly different in age groups, gender, education, occupation, location and other variables. The older, low education level, females have more cultural influence in the construction of perception towards ill-health and medication practices. They also have more belief in spiritual causations, cultural causation in ill-health. The younger, males, having higher education levels were more influenced from the bio-medicine causation of illness and medication practices. There was also a significant change in drinking water practice, sanitation, use of toilets, going to the hospital and using allopathic medicines in the past ten years and the interviewed year. However, socio-cultural influences were found in the perception of ill-health and medication practices among the respondents of Magar society.

10.1.3 Health Care and Medication Practices among the Magars

Based on the first objective, the modern health care (bio-medicine) system was found assimilated in the Magar society and inseparable in their health care whereas medical pluralism was found among the Magars. The Magars have taken health services from the local health posts (government line agency), medicine shops, hospitals of local or neighbouring districts. They also visited cities like Pokhara, Butwal, Bhairahawa, Chitwan, Kathmandu and abroad due to access of road and connectivity facilities. Similarly, they also consumed Ayurvedic medical services, Acupressure (Chinese) Medicines, traditional healers such as *lāmā* or *wārcha-bharmi* (shaman) as well as local herbs and shrubs, cultural healers. In addition, they promise (*bhokal*) and worship local god *pitripujā*, *kulpujā*, *chandipujā*, *māi/māyupujā*, *bāyu/bāipujā*, *bhuyānr*, *bhumyā*, *harelo*, *nwāgi* (*chhomyāng*), *deurāli/bhanjyāng*, *onghya*, *sirung* and *kolākhāli*, *sikāri* and *banaskhandi*, *bajibajai puja*, *mandali puja*, etc. They also offer sacrifices to evil spirits such as *bhutpret*, *pichās*, *masān*, *ledini/nidhini*, *rakchhes* for good health and well-being, prevention of misfortune. Furthermore, they conduct or worship *bhimsenpujā*, *siddhāpujā*, *simyābhumyā*, *bhairam*, *jhānkri*, *goth puja*, *barāhā*, *thāni*, etc.; local shrines such as Alam-thān, balām-thān, local kot/jongs (forts), tamkikotdeutā, lhumpekideutā, akalādevi, khand (khondā) puja, and other local shrines. Similarly, they also worshiped *palpasatyadevi*, *dhorbarāhā* and *chhabdībarāhā* of Tanahun and other shrines located in surrounding districts for good health and well-being, and prevention of misfortune. Besides that, they worshiped Hindu gods such as Jagatradevi, Dergadevi, KalikaDevi, Bishnu god, Lamxi, Saraswati, Bramhā and other Hindu gods. They also worship Buddhist gods. Some Magars also worshiped Christian gods and goddesses.

There were also found having beliefs on *Boksi* (witchcraft, sorcery) practices for causation of illness whereas they do not blame the suspected person publicly, but talk on the backside of the blamed person. Faith healing practices have been found through *Ghānto* folk lyrical dance in the study area. If someone or a family member or dancer falls in illness or cannot heal from allopathic or sometimes cannot buy bio-medicine, they go for dancing *Ghānto* and become devotees of Ghānto god and goddess to heal their illness.

In Magars culture, rituals, feast and festivals, worships, folk song and dances, way of living, customary institutions and social systems are connected with the perception of health, illness and healing practices, health and well-being as well as their awareness towards health issues. The Magars of Syangja celebrate *Baisākhesakarāti*, *chandipurnimā*, *Dasaharā*, *sāunesakarāti*, *janaipurnima* and *Krishna astami*, *teej*, *Badādashain*, *Tihar*, *Kattikethulaekadashi*, *pandhra push*, *Maghyāsakarāti*, *Basantapanchami*, *Younāt*, *Chaitedashain* festivals. Similarly, they also have practice of *nātle* (holiday) in *ausi* and *purnimā* of lunar calendar for worship and feast. In addition, *Ghānto*, *Mārūni/Sorathi*, *Younāch*, *Jiwai-Māmā*, *jhorā*, *jhāmryā*, *rodilhing* and seasonal songs were major songs and dances in the study area. Similarly, singing tune of *sālijyu*, *yāhānimāyā*, *sunī māyā*, *chudkā*, *thādobhākā* and so on were also found among the Magars. These dances and songs are organized on the occasions of feasts and festivals. On such occasions, they prepare nutritious food, a holiday for rest or recreation, worship for mental satisfaction. It also provides an intimacy within family and kinships through gathering which is also helpful to health and well-being. However, misuse of alcohol, early marriages due to cultural influence, overeaten during the feast and festivals, keeping stale or mouldy food in the feast and festivals practices is deteriorating the health of the Magars' health. Besides this, health care practices are found in Magar rituals.

In pregnancy, some foods are prohibited. The husbands of pregnant women are prohibited to act as priests (*umarā*), perform sacrifices and hunting for the better health of mother and fetus. In childbirth, the elder and experienced women or *sudeni* from the relatives or village help to mother with childbirth, sanitation, cutting the cord, management of placenta and neonatal care. In the naming ceremony, *bhalāyo* (a kind of plant which has allergic properties), *siru* (a kind of thorny grass), *kurilo* thorn, and other thorny and poisonous plants are burnt. The smoke of fire known as *dhup* is spread to a new born baby believing that it prevents from illness caused by the respected plants and to develop immunity power (for vaccination). The weaning ceremony (*chhokāske*) ritual is considered as additional food for the child. The insufficient breast-feeding stage starts after the 5th or 6th months of childbirth. *Gunyucholi*

yāhāke, and *chhewār* are the customs of completing childhood or adolescence and towards maturity of child. Marriage cross-cousin (*māmācheli- phupuchelā*) practices are existed in the Magar community, however, such custom is decreasing. In marriage custom, *dhogbhet* (greeting with kinships and relatives) ritual increases the intimacy. The marriage patterns found from the study were as 5.63% under 15 & 15 years old age (9.59% among the female, 1.59% among the male), 18.74% age between 16-18 years old (29.02% among the female, 8.20% among the male) and 22.77% age between 19-20 (26.42% among the female, 19.05% among the male). It shows that 47.12% do not cross the 20 years old and 65.03% of females do not cross 20 years in marriage age of the Magars. Early marriage hampers education, development of skills and their careers. It also can result health hazards. "Individuals and societies tend to respond to health problems in a manner consistent with their culture, norms and values" (Cockerham, 2012, p. 1) and "health is a common theme in most culture" (Park 2005, p.12).

In the field survey, 68.6% of households had suffered from some kind of illness either respondent him/herself or his/her family members within one year during survey time. Among them, 43.6% households had visited medical shop/private clinics at first, 24.8% households had visited shaman (*lāmā/ wārcha bharmi*) at first, 22.2% visited hospitals at first, only 8.7% households had visited local governmental health institutions at first and 0.5% household visited the church in illness. Furthermore, in the past five years, 57.7% of households had visited government local health institutions and 40.6% had not gone when fallen into illness. In contrast, 88.4% of households had visited private health institutions, and only 9.3% were not gone in private sector. Similarly, 79% of respondents' households had consulted a local shaman or traditional healers and only 18.2% of households had not consulted a shaman (traditional healer) in the last five years later. In addition, only 45% of households were teaching their indigenous knowledge regarding ill-health and medications, local medicinal herbs and shrubs. The 55% of households had no practice in teaching indigenous knowledge of health and healings. Similarly, only 16.4% of respondents' households collect, processing and store the local herbs and shrubs for medicinal use. This indicates that the Magars are going to lose their indigenous knowledge regarding health and healings.

In the Magar villages, 53.9% of households stored allopathic drugs and only 14.6% of households did not store allopathic medicines for self-medication. A proportion of 58% of respondents said that they had a practice of self-medication. Only 42.6% respondents had felt cheap for traditional medicine, 17.6% of respondents for allopathic treatments and 35.7% of

respondents had felt both expensive. Furthermore, the majority of respondents felt practically expensive (expensive 34.1% and very expensive 33.3%) to afford modern medicine. Only 28.3% of respondents responded practically modern medicine as affordable. Occupation-wise, occupation having as Ex-Army/Pensioner/Army in India or the UK (51.4%), housewife (35.6%), foreign employment (34.4%), job/service in Nepal (28.6%) had a higher percentage in capability to afford of modern medical care. Beside this, 58% of respondents found health workers or health services provided through NGOs/INGOs in the Magar villages. Similarly, 81.1% of respondents found the presence of herbal medicine sellers and 18% of respondents had met the presence of health workers of the organizations or private institutions selling health care service at home service in the villages.

In the survey, 32.1% of households had childbirth within the last five years. Among them, 37.3% of households had a delivery at home, 6.9% in local governmental health institutions, 12.3% in local pharmacy/clinics, 43.1% in private hospitals and 0.5% in higher centers giving childbirth. Among the childbirth giving at home, assistance taking for childbirth from mature women or kinship 38.0%, from traditional birth attendance (*sudeni*)11.8%, from female health volunteers, 15.8%, from inviting health worker at home 19.7% and 14.5% mothers were not taken any assistance to give birth for the child. In such a way, bathing practice for a new born baby, 49.2% households were found doing it immediately after the birth, 6.3% households did within 2-3hours and 25.8% within 24 hours and 6.0% respondents had after a week. It was also found cultural practice of disposing of fallen umbilical cord of a new born baby where 50.8% buried near the hearth or oven, 27.5% kept safely and 10.2% respondents some part buried near hearth or oven and some parts kept safely for preparation of *Jantar*. About the vaccination practice, 1.7% of households had not provided vaccination for their children and 6.0% of respondents had no idea about the vaccination and prevention of illness. Similarly, the Magars have their indigenous knowledge about public health, nomenclature of illness, healings, healers, health care, human anatomy and physiology and health in their own Magar language.

10.1.4 Socio-cultural Perceptions towards Health and Illness

Based on the second objective, the researcher has explored the perceptions of the Magars on ill-health and medication practice in their socio-cultural context. Their perceptions towards health, illness and medication are found on the basis of their cultural and social setting. Magar cultural, social values and norms had influenced the construction of perceptions. The Magars worship several local gods and goddesses in their culture. The findings show that the

respondents of 48.3% have a strong belief, 41.5% partial beliefs and only 7.5% had no belief in god-spiritual causation of illness and misfortune. In Chi-Square (χ^2) test there was a significant association found between the respondents of different *age, sex, education level, occupation* and group-wise in their perception of belief in god-spirit for causation of illness. Further, the majority of respondents (more belief 47.2% and partial belief 40.7%) had a belief in the causation of illness due to doing dirt or pollution at god-*thān* or shrine. Similarly, the Magars in the study area worship evil spirits in their culture. Likewise, the majority of respondents (strong belief 30.3%, partial belief 51.1%) had belief and only 16.2% of respondents had no belief in the causation of illness and misfortune through evil-spirit. In addition, it was found that 66.8% of respondents (strong belief 19.3%, partial belief 47.5%) had belief in witch and sorcery (Boksi/Boksā) to cause illness. A maximum of 85.9% respondents (strong belief 39.8%, partial belief 46.1%) was found having a belief in the causation of illness due to *Grahadashā*. The lower education, older age groups had found higher belief on Chi-Square (χ^2) test. In Likert scale or summated scale distribution analysis cumulatively 68.2% of respondents were found having believes in spiritual causation of illness and misfortune.

About the causation of illness knowledge of bio-medicinal theory, the respondents of 54.4% were having knowledge, 33% heard only and 12.6% respondent had no idea about the micro-organism can cause illness (germ theory) in Magar society. In Chi-Square (χ^2) test, there was a significant association found between the respondents of different *age, sex, education level, religion, occupation, and family types* groups in their knowledge on micro-organism and causation of illness. Similarly, lay concept to the causation of increasing non-communicable diseases, found that majority respondents told food habits (modern food 32.9%, careless in food taking habit 29.6%), 8.6% told misuse of modern medicines, 3.5% respondents marked as mental tension and 9% respondent had no idea about the cause of increasing non-communicable diseases. In Chi-Square (χ^2) test there was a significant association found between the respondents of different *education level, age, marital status* wise groups in their perception of increasing non-communicable illness.

In the survey, perception towards reproductive and maternal health, and HIV/AIDS was included. About the self-medication or misuse of medication in pregnancy, it was found that the respondents of 48.7% having knowledge and aware towards the modern drugs could be harmful or create side effects for foetus in pregnancy in doing misuse or taking without doctor's recommendation. Further, 41.2% of respondents had only heard and 10.1% of

respondents were unknown about the problem. The life-threatening morbidity of pregnancy (eclampsia and pre-eclampsia condition); respondents of 56.8% found aware about the illness, 19.8% respondents were unknown and 19.5% respondents told minor illness. In-home delivery for child birth, the sanitation and umbilical cord cutting process or management is an important due to spreading infections such as Tetanus disease. The perception on cutting the umbilical cord in-home delivery, respondents of 53.8% used clean blade and scissors, 11.3% clean sickle/small sickle knife, 1.3% whatever cutting materials, 0.3% fresh split cane (*Choyān*) and only 33.3% respondents told sterilized blade or scissors would be better. The higher education and younger age had found higher knowledge about the importance of sterilization and sanitation in-home delivery. Similarly, in Likert scale analysis, 86.6% of respondents were strongly positive about modern MCH care for better health. About the HIV/AIDS illness 78.9% of respondents were told having knowledge. Among them, 53.4% of respondents gave right responses (unsafe sex, blood, body fluid, injections) and 41.2% of respondents shared that only unsafe sexual intercourse in the mode of transmission of HIV/AIDS.

In the same way, it was found that traditional medicines could cure simple or minor illness 74.2% and had most of illness 12.3% respondents. And 8.2% of respondents had no belief in traditional medicine and healing system. In Likert analysis, cumulatively 73.6% had their belief in traditional healings. But about the modern (allopathic) medicines, most of all illness could be cured 58.2%, some illness could cure 32.5%, no belief in curing all illness 2% and unknown about the issue 7.2%. Similarly, knowledge about the side effect of allopathic medicines was found 21.4% have the knowledge, 47.2% have heard and 31.4% respondents were unknown about the having side effect of allopathic medicines. In Likert analysis, 76.7% of respondents have a tendency of going modern health care (bio-medicine) system.

The Magars have several cultural practices to traditional healing. They sprinkle alcohol in *thān* after smearing *thān* and offer to god and goddess. About the sprinkling alcohol in the *thān* in worshiping culture, 12.6% told to kill or chase micro-organism/insect, 6.1% to banish the evil spirit, 22.5% to please the god/goddess, 48.7% traditional custom, 0.2% no allowed due to different religion and 9.9% had unknown. Similarly, Magars use the medicinal plant Titepāti (wormwood/mugwort) in every worships, ritual and cultural works. In using Titepāti (wormwood/mugwort) 23.4% of respondents told being a medicinal plant/ritually pure, 11.3% being smell to chase insects, 60.1% traditional customs 1.9% to please the god and goddess and 3.3% were do not know. Magars collect local plants such as *Bhalāyo* (sumac), *Ban kurilo* (asparagus), *Siru* (cogon-grass/hay grass) and other plants (which became allergic,

poisonous and thorny) burned to make smoke in the house on naming ceremony (*nwāran*) and given *dhup* for newborn baby. About in this cultural practice; 14.6% of respondents told to prevent from the illness, 47.6% prevent from those poisonous plants, 27.5% traditional custom, 1.7% both prevent from the illness and prevent from the poisonous plants, 0.3% did not do this custom, and 4.6% told don't know. In the villages of Nepal, when a baby or child carrying outside from the home or evening time, they put the *tikā* of turmeric or ash or charcoal on the forehead of the child then walk outside from the someone home. About these cultural rituals, respondents of 55% told opinion of preventing from evil-spirit, 15.7% wishing for good health, 23.7% traditional custom, 3.6% superstition, 0.5% don't do due to different religion and 1.4% told don't know responses. Similarly, in cultural practice of tied round sacred thread (*dhajā*) and sprinkle *achhetā* in the base of *Bar*, *Pipal* or big trees in the way or paths when carrying baby 30.3% of respondents had an opinion on preventing from the evil-spirit, 32.2% wishing not become ill, 7.1% prevention of local illness *somokke*, *mos* etc. 24.2% traditional custom, 3.6% superstition and 2.2% told don't know about the custom.

In Magar culture and society cross-cousin (*mamācheli-phupu chela*) marriage is in practice as a customary system. About this custom, the respondents of 26.3% told knowing health status each other, 11.8% to prevent communicable illness, 52.2% only keep kinship relations, 9.7% were unknown about the cause of custom. As per bio-medicine, there could be a probable risk of hereditary defects or illness in such marriages. Regarding this matter, 9.6% of respondents told known the risks, 41.0% heard only and 49.4% were not unknown about the risks. Similarly, In Magar villages, when someone dies in the house, in death ritual they carried out the deceased for cremation form home with villagers. After the carried out the deceased from house, then they smear (clean) from inside to outside direction. About this custom, the respondents of 35.7% were told to push out the soul of a deceased person, 15.7% traditional custom and 18.4% to clean the house and make ritually pure, 8% to throw out disease or illness from the deceased house and 19.8% didn't know the reason about the custom.

The perceptions towards causation of mental illness among Magars; respondents of 17% being anger Godlings/God spirit, 11% envy by the Ghost, Masan, Nidini, etc. Evil spirits, 41.8% told taking excessive thinking/ tension, 12.3% family causes such as deficiency of security and love from the family (12.3%), 7.5% Insecurity from the relative and society, and 10.4% respondents unknown about the causes of the mental illness. Similarly, in Likert scale analysis there was found that respondents of 68.1% had found having a strong positive response, cumulatively 86.6% of respondents had found having a positive response to mental illness can be cured and need of support for a mentally ill person.

The habits of over-eating, under-eating and timely not eating, using stale and musty food could cause to illness. Hygienic and balanced nutrition in food can help for a healthy life. Respondents of 75.9% had knowledge, 18.7% had unknown about the causation of illness due to unbalance food in daily life. But 5.3% of respondents had not agreed with the causation of illness due to unbalance food in daily life. Similarly, perception towards junk foods, respondents of 57.5% known, 31.4% heard only and 11% don't know in the insufficiency of nutrition for the daily life. Higher education levels had a more positive response about the causation of illness due to unbalance food in daily life. In addition, smoking, alcohol and conducting bad or risky habits/ avoiding ethics, morals are also causing the illness. For this issue; in Likert scale analysis 43.6% percentage respondents had extremely agreed and 96.2% of respondents had positive agreed to the Likert scale statements. Furthermore, about the occupations health and safety in a local setting, respondents of 96.1% found agreed and aware, and 3.8% of respondents were uncertain or don't know with taking simple precautions for doing work could be prevented from illness and injury.

The government had provided health services through sub-health posts, health posts and primary health care centre in the study area. In the survey, only 44.8% of respondents found known about the type of health institution in their respected VDCs. Only 11.9% of respondents found knowing about free medicine distribution services through governmental health institutions. The majority (52%) respondents do not know what kinds of vaccination were provided by their respected VDC's governmental local health institutions. Similarly, 79.1% of respondents were unknown about qualification and recruited posts of health workers in the health institution of their respected VDCs. In addition, 18.9% of respondents had satisfied with the local health care of governments. Among the unsatisfied respondents, the reason of dissatisfaction was found as; 24.3% respondents told deficiency of medicine, 16.4% respondents told irregular presence of trained health worker in the institutions, 16.4% not regular and always opening and unavailable in an emergency, 18.9% respondents told far away situated governmental health institution, 14.3% respondents question raised quality of service, 8.2% respondents were told rude/irritating behaviours or unusual behaviours of government health workers. Similarly, 49.5% were clearly understood about counselling or instruction, 40.7% understands partially and 9.7% felt difficult to understand counselling or instructions provided by the government health workers. Furthermore, about the doctor-patient relationships, there had found respondents of 65.4% had a perception of generally helpful behaviour, 11.6% had felt perception of rude/irritating behaviours, and 9.6% felt

perception of doing discriminating behaviours, and, 0.2% respondents felt insulting and dominating behaviours from the doctors, nurses or health workers at governmental hospitals of the country.

The constitution of Nepal has the provision of health as a fundamental right and ensuring health care for all the citizens of Nepal. About this, the majority of Magars respondents (55.2%) found unknown. only 7.5% of respondents were known, and 37.3% heard only. Respondents of lower education level, older age groups, occupation having ex-army/pensioner of army in Indian/UK, Business and agriculture, marital status wise married and single (widow/ widower) were higher percentage in unknown.

10.1.5 Changes in Ill-health Perceptions and Medication Practices

Based on the third objective, there are several changes among the Magars. Their traditional culture, tradition, way of living, social system, customary institutions were found changed. The indigenous knowledge of the Magars regarding health, healing and medications were going to disappear with changed socio-cultural situations. Cross-cousin marriages (*māmācheli–phupu chela*) were significantly reduced and connecting kinships in far distance through marriage were started to practice. The *ghāntu* dance culture disappeared from the other VDCs and only practiced in Pindikhola, Pelakot and Nibuwakharka VDCs. The *Maruni/sorathi* (*karhangnāch*), *rodi* custom and several folk dances and songs are rarely seen in the study area. The Magars were leaving to worship of several local gods and goddess; which, had connected with ill-health and misfortune. Most of the Magar villages were suffering from migration; for employment opportunities, better education and better lifestyle. Therefore, the agricultural occupation had found declining and increasing foreign employment for subsistence. The traditional healing system; *lāmā/wārcha bharmi*, indigenous knowledge of local medicinal plants, traditional food systems are found degrading situation. In the last twenty years, the rural road was expanded every VDCs and village, mushrooming private medicine shops, clinics and private health care in the study area. The drinking water and sanitation program also expanded in the study area in few decades.

In the survey, changes in drinking water practices were found. In 10 years, using filters increased from 2.7% to 9.7%, boiling practice increased from 3.5% to 23.1%. And the paired-samples t-test shows that there was a significant difference in the drinking water practices for 10 years ago ($M=1.15$, $SD = 1.275$) and after 10 years ($M=1.85$, $SD= .593$) conditions; $t(14.520)$, $p=000$ (which is lower than $p=.05$). Similarly, the practice of washing hands with water and soap before taking food practice was found increased from 17.6% to 74.2% in the

past 10years gap. The paired-samples t-test shows that there was a significant difference in the washing hand before taking food habit and practices for 10 years ago ($M=2.52$, $SD = .839$) and after 10 years ($M=1.67$, $SD= 3.943$) conditions; $t (5.314)$, $p=000$ (which is lower than $p=.05$). After using toilet, washing hands with using water and soap practice and awareness were found increased by 52.8% and reached 93.7% in the past ten years.

Toilet having households found reached 97.8% from 73.1% in the past ten years. The paired-samples t-test shows that there was a significant difference in the having toilet in the respondent's house for 10 years ago ($M=1.27$, $SD = .444$) and after 10 years ($M=1.02$, $SD=.147$) conditions; $t (14.189)$, $p=000$ (which is lower than $p=.05$). Further, about the toilets, water-sealed latrine with raw wall reached 25.5% from 5.3% and modern latrine reached up to 39.6% from 5.5%. The paired-samples t-test shows that there was a significant difference in the types of toilets in the respondent's house for 10 years ago ($M=20.37$, $SD = 32.662$) and after 10 years ($M=2.85$, $SD= 1.180$) conditions; $t (13.365)$, $p=000$ (which is lower than $p=.05$). Similarly, regularly toilet used respondents was found increased up to 93.4% from 63.8% and paired-samples t-test shows, there was a significant difference in the regular using habits toilets in the respondent's house for 10 years ($M=2.11$, $SD = 1.689$) and after 10 years ($M=1.08$, $SD= .415$) conditions; $t (15.039)$, $p=000$ (which is lower than $p=.05$). The people when away from their house, practice of open defecation found reduced and practice of asking neighbouring latrine practice was increased up to 65.7% from 17% in the past 10 years duration. The paired-samples t-test shows that there was a significant difference in the avoiding open defecation habits toilets when working in field or away from the house for 10 years ($M=1.18$, $SD = .389$) and after 10 years ($M=1.89$, $SD= .575$) conditions; $t (29.229)$, $p=000$ (which is lower than $p=.05$).

In the past 10 years, the traditional firewood oven user households for cooking had reduced by the 45% and the remainder 46.9%. That is substituted by the LP Gas oven, improved firewood oven and bio-gas oven. Regarding oven for cooking, the paired-samples t-test shows, there was a significant difference in traditional fire-wood hearth and adding modern fuels for cooking of respondents' households for 10 years ago ($M=1.18$, $SD = .389$) and after 10 years ($M=1.89$, $SD= .575$) conditions; $t (29.229)$, $p=000$ (which is lower than $p=.05$).

The pattern of going to hospital or modern health care instantly was found increased by 45% when falling illness and paired-samples t-test shows that there was a significant difference in visiting doctor or modern medical institution of respondents for before 10 years ($M=2.27$, $SD= 6.760$) and after 10 years) ($M=3.14$, $SD = 6.675$) conditions; $t (2.824)$, $p=005$ (which is lower than

$p=.05$). Similarly, the visiting to *lāmā* or *wārch bharmi* (shaman or traditional healers) reduced by 28.4% when falling illness. However, when allopathic treatment fails or could not cure then visiting *lāmā* or *wārch bharmi* was increased by 28.8%. Furthermore, church-going for healing households had appeared by the 0.5% in the past 10 years.

About the food habits and nutrition, there had found that traditional food regularly consumed household reduced by the 41% and sometime or occasionally consumer increased by the 49%. The paired-samples t-test shows that there was a significant difference in traditional food consuming pattern of respondents for 10 years ago ($M=2.03$, $SD = 5.504$) and after 10 years ($M=2.84$, $SD= 3.867$) conditions; $t (5.053)$, $p=000$ (which is lower than $p=.05$). But about the junk food consuming, mostly consumer increase by the 4.9%, sometime or occasionally increased by 17.8% and unknown about junk food, reduced by 12.4%, least/very few decreased by the 10.2%. The paired-samples t-test shows that there was a significant difference in pattern of consuming junk food in Magar villages for 10 years ago ($M=15.61$, $SD = 33.228$) and after 10 years ($M=3.41$, $SD= 10.813$) conditions; $t (9.411)$, $p=000$ (which is lower than $p=.05$).

The knowledge about the communicable and non-communicable illness was found unknown respondents were reduced by 16% and paired-samples t-test shows that there was a significant difference in knowledge about the difference between communicable and non-communicable diseases among the Magar villages for 5 years ago ($M=97.45$, $SD = 1.152$) and after 5 years ($M=96.89$, $SD= 1.049$) conditions; $t (16.657)$, $p=000$ (which is lower than $p=.05$).

About zoonotic illness or illness transmitted from animals or birds such as bird-flu, swine flu, there had found unknown respondents decreased by the 23.3% and known respondents increased by 17.6% in the last 5 years and paired-samples t-test shows, there was a significant difference in knowledge about the difference between communicable and non-communicable diseases among the Magar villages for 5 years ago ($M=97.61$, $SD = 1.151$) and after 5 years ($M=96.97$, $SD= .972$) conditions; $t (16.953)$, $p=000$ (which is lower than $p=.05$). Similarly, about HIV/AIDS, unknown respondents were reduced by 11% and known respondents increased up to 78.9%. And paired-samples t-test shows that there was a significant difference in knowledge about HIV/AIDS among the Magar villages for 5 years ago ($M=96.96$, $SD = 1.401$) and after 5 years ($M=96.63$, $SD= 1.224$) conditions; $t (8.862)$, $p=000$ (which is lower than $p=.05$).

In the last 5 years, unknown respondents about the Cancer illness had found decreased by 17% and heard only increase by 4.2%, known increased by 12.7%. The paired-samples t-test shows that, there was a significant difference in knowledge about Cancer diseases among the Magar villages for 5 years ago ($M=97.26$, $SD = 1.102$) and after 5 years ($M=96.79$, $SD=.833$) conditions; $t(14.143)$, $p=000$ (which is lower than $p=.05$). About Hypertension and heart illness; unknown respondents reduced by 14.6% and known respondents increased by 14.6% up to 42.5% in the past 5 years. In paired-samples t-test shows that there was a significant difference in knowledge about Hypertension and heart diseases among the respondents for 5 years ago ($M=97.20$, $SD = 1.096$) and after 5 years ($M=96.76$, $SD= .865$) conditions; $t(13.251)$, $p=000$ (which is lower than $p=.05$). Similarly, unknown respondents about diabetes mellitus illness were found decreased by 17.6% and known respondents increased by 14.8% and reached up to 40.7%. And paired-samples t-test shows that there was a significant difference in knowledge about diabetes mellitus among the respondents for 5 years ago ($M=97.22$, $SD = 1.084$) and after 5 years ($M=96.72$, $SD= .767$) conditions; $t(14.458)$, $p=000$ (which is lower than $p=.05$). Furthermore, knowledge towards chronic kidney failure (CKD) illness; the unknown respondents decreased by 16.6%, heard only increased by 5% and reached up to 49.4%, known increased by 11.5% and reached 32.7%. And, paired-samples t-test shows that there was a significant difference in knowledge about chronic kidney failure (CKD) diseases among the respondents for 5 years ago ($M=97.48$, $SD = 1.168$) and after 5 years ($M=97.03$, $SD= 1.022$) conditions; $t(13.285)$, $p=000$ (which is lower than $p=.05$).

In Magars, there has been found changes in knowledge of family planning and reproductive health. In the survey, respondents of known about family planning increased by 15.3% in the past 5 years and reached up to 60.4%. And, paired-samples t-test shows that there was a significant difference in knowledge about family planning methods among the respondents for 5 years ago ($M=97.03$, $SD = 1.192$) and after 5 years ($M=96.69$, $SD= 1.042$) conditions; $t(10.773)$, $p=000$ (which is lower than $p=.05$). Similarly, knowledge towards unwanted pregnancy and abortion rights, there was found respondents of known increased by the 15.6% and reached up to 28.1% in last five years, heard only increased by 2% and reached up to 41.7%. In paired-samples t-test shows that there was a significant difference in knowledge about unwanted pregnancy and abortion right among the respondents for 5 years ago ($M=97.83$, $SD = 1.162$) and after 5 years ($M=97.32$, $SD= 1.178$) conditions; $t(14.626)$, $p=000$ (which is lower than $p=.05$). Furthermore, knowledge towards antenatal check-in pregnancy duration was found respondents of unknown were decreased by 8.3% and up to 26.1%, respondents having

knowledge of antenatal check-up should be done at least four times in pregnancy duration were increased by 11.8% and uplift up to 37.9%. The paired-samples t-test shows that there was a significant difference in knowledge about antenatal check-up during pregnancy among the respondents for 5 years ago ($M=35.69$, $SD = 45.929$) and after 5 years ($M=27.44$, $SD=42.579$) conditions; $t(6.384)$, $p=000$ (which is lower than $p=.05$).

However, there are several changes in health practices and knowledge among the Magars, the changing process in gradually progress. But traditional knowledge, technology and skill regarding ill-health and medication were losing process among the Magars.

10.2 Conclusion

Health, illness and medication practices are social phenomena. The perception of health, illness and medication practices of community or individuals influenced from numerous social elements, social and natural environments. The socio-cultural backgrounds of individuals or communities help to construct concepts and understandings towards health, illness and well-being. The Magars have a distinct socio-cultural background in the context of Nepalese social, cultural, linguistic, ethnic (horizontal hierarchy), caste (vertical hierarchy), geographical and biological diversities. Here, discussion about perceptions towards health, illness and wellbeing, medication practices in socio-cultural background of the Magars is concluded.

Primarily, this research-validated argument of previous researchers who argue that human interaction in health, illness and medication practices are mediated upon their own culture, norms and values of a society. The relation of individuals and societies with health problems is responded consistently in a manner of socio-cultural factors. The linguistic and cultural variation of a local setting differs in the perception of ill-health and medication practices among the indigenous peoples. The indigenous knowledge and skills constructed and evolved in adaptation process with the local environment in a long historical duration of generation-to-generation transformation, and it also varies with available natural resources, local production, development of technology and consumption. The relation between a society with health, illness and medications mainly the Magars of surrounding Tamkikot hill of Syangja district can be understood as a broad spectrum of indigenous health and wellbeing interactions and functioning of society. The constructed perceptions on health and illness of individual or society lead to health-seeking behaviour (medication practices), however, that also influences other social factors such as socio-economic status, availability of health care facilities, quality and cost of health facilities, physical distances to get service, advertisements in media (media influence) and

relatives views. It is also argued that the changing situation of social phenomena in the local setting, the indigenous knowledge and skills are in the way of disappearances.

Second, this research has described the health care and medication practices among the indigenous peoples, Magars in the local setting and their socio-cultural background. In this research, from the mixing qualitative and quantitative findings, it can be argued that the popularity of bio-medicine had been increasing among the Magars, but there was doubt of quality and equity of health care in local settings, choices of quality of health. The local health care depended upon low qualified health workers and quacks of medicine shops. Furthermore, the majority of the Magar villagers had not a clear understanding of qualification, education level of health workers and health care organizations. However, there was a medical pluralism setting. However, they had not totally forgotten about their indigenous/ traditional health care practices, faith healings and cultural healing. Besides that, other health care systems such as Ayurveda, Homeopathy, Chinese Acupressure, Naturopathy and other religious healing practices were accessible to the Magar's habitat due to urbanization and development. Although, the Magars who were using traditional health care practices felt slightly expensive in comparison to allopathic medicine. It can be argued that the mode of production is changed due to development and political changes. Therefore, subsistence agriculture and local occupations are replaced by foreign employment and remittance and other professions to earn money. They have to buy chickens, eggs, goats and other products from the market to perform traditional healing practices and see healers. On the other hand, due to cost matter for visiting qualified doctors or hospitals (bio-medicine), and difficult to access, self-medication and medicine storing practices have been prevailing.

Since bio-medicine is dominant, and the popularity of bio-medical knowledge is increasing among the Magars. In an opposite way, their indigenous knowledge and skills of traditional health care, healing practices in health, illness and well-being are reflected in their cultural and ritual performances. The qualitative and quantitative data show that they had indigenous knowledge and practices in collecting and using medicinal plants and substances which are available in the local environment. However, the knowledge transforming trend to their offspring is decreasing. From this fact, it can be argued that changing society through development, education, media and other means, the local knowledge is in a declining stage which leads to dependency on corporate economy or world market instead of the indigenous social system.

Third, this research explored the socio-cultural perception towards health, illness and wellbeing. Through both qualitative and quantitative findings, this can be argued that the perception towards ill-health and medications among the Magars had an influence through their socio-cultural background, lived geography and the local environment. Although they were developing their concepts towards bio-medical concepts such as micro-organism, genetic causation, metabolic causation and other bio-medical knowledge, they have a belief in spiritual causation of illness, traditional healers *lāmā* or *wārcha-bharmi*, faith healing in Ghanto folk dance, cultural healings, Jaisi (astrologer), priest of local shrines, their ancestral local god and goddess, shrines of local and neighbouring districts, and worship of nature and natural objects. Similarly, the perception towards communicable diseases, non-communicable diseases, maternal-child health (MCH), reproductive health, HIV/AIDS, STI found increasing towards bio-medicine concepts. There was a dilemma using traditional healing process due to the publicity of bio-medicine. But they had a perception of few illnesses or some particular illness could heal from the traditional healings. Similarly, their perceptions in cultural and ritual practices were found connected with health, fear of illness, wellbeing and misfortune. Their knowledge and perceptions of health, illness and medications were preserved in their own language and culture. The Magar language carries its indigenous knowledge in the local setting. Therefore, it can be argued that changing in linguistic and cultural matters of the Magars, there will bring change in their indigenous knowledge and perception as well as practices. Besides that, knowledge of the Magars towards health care provided through government line agency, constitutional, legal and health policy was found in weak level. So, it can be argued that, the mainstream health programs were not launched according to giving concentration in Magar language and culture at local level. Similarly, from this research, it can be argued that human perception, knowledge, experience and responses would vary according to age, gender, social status, level and nature of education, occupation, location (VDCs), marital status and other forms of social performance with ill-health, and medication within the ethnic group. In addition, the younger generation and educated through the mainstream education are found low knowledge in their culture and ritual, history, indigenous knowledge and skills and their language. Therefore, it can be argued that the indigenous knowledge and skill of local peoples are endangered due to rapid changes in society and knowledge, education and media regarding health issues.

Fourth, this research has analysed the changes in health perceptions and medication practices in local settings. There have been changes in infrastructure-related drinking water, transport connectivity and access, educational facilities, health facilities and other facilities in

comparison to three/four decades ago and later. So, it is argued that there would be social and cultural changes with time-being. By these changes, both qualitative and quantitative findings show that there were significant changes in health practices, perceptions and knowledge about health and illness among the Magars in local settings. The bio-medicine concept towards health, illness and medication has been increasing and the traditional health practices slowly decreased. The traditional shamanism (*lāmā/wārchā bharmi*)'s number was decreased, but traditional shamanism and faith healing were replaced by the church such as *Sachchai*, Mata and other religious superstitious beliefs where Magar culture and indigenous knowledge cannot be reflected.

Finally, health, illness and medication (healing) practices are social phenomena. The linguistic and cultural variation in local settings; there can vary in the perception toward ill-health. The constructed perception in socio-cultural context leads to health-seeking behaviours in a medical pluralistic setting. But the socio-cultural factors again influenced to search for health care services and consumption of health services. And this research is a local perception on ill-health and medication practices of the Magars based on their own culture and social setting through the sociological eye.

10.3 Limitations of the Study

This study was entirely related to the indigenous peoples, the Magars of Syangja district of Nepal in the issue of perception of ill-health and medication practices in their socio-cultural context. The research had the following limitations:

- The study had not included the medical aspects (laboratory investigations, clinical diagnosis and access to the health services) to find out health situation of respondents.
- The study had not included other ethnic/caste groups rather than indigenous peoples, the Magars.
- The study had covered only the Magars of nine VDCs of Syangja District. As compared to the total number of potential respondents of the whole of Nepal, the sample size was small.
- The study had covered only socio-cultural perception towards ill-health and medication practices rather than other issues of indigenous peoples Magars.

10.4 Recommendations for Future Research

The Magars are scattered all over the country, however, their main historical habitats are the Basin of Sapta Gandaki Rivers, Rapti and Bheri Rivers. There are several subjects regarding

Magars to explore because very few research works have been conducted about the Magars. Here, from the above discussions, findings and results, the following recommendations are made for future study:

1. The Ghantu folk dance and cultural healing practices among the Magars,
2. Impact of modern health care system (bio-medicine) among the Magars,
3. Situation of Ethno-medicine among the Magars,
4. Disappearing traditional healers and social impact among the Magars,
5. Migration and health among the Magars,
6. Factor associated in increasing HIV/AIDS among the Magars,
8. Socio-cultural and health impact among the Magars due to infrastructure developments,
9. Factors associated with increasing non-communicable illness (e.g. cancer, CKD, Heart diseases, etc) among the Magars,
10. Socio-cultural awareness about the communicable illness among the Magars,
11. Child and maternal health care systems among the Magars
12. Mental health in Magar's socio-cultural practices.

10.5 Contributions of the Study to the Discipline of Sociology

The detailed study of perception on ill-health and medication practices in socio-cultural context among the indigenous peoples Magars in their daily livelihood would be interesting to the sociologists to an understanding on health care situation, traditional healing practices and perception of change in traditional concepts of ill-health and medication among the Magars which will be effective for dealing in the health care system and development mechanism.

The earlier western scholars Kirkpatrick (1811), Hamilton (1818), Oldfield (1880), Wright (1877), Vansittart (1906) were mentioned few aspects of the Magars. The westerners were looking at the Magars and other indigenous groups as a military tribe or warrior and gentlemen of Nepal. After the changes of 2007 BS, Nepal opened for foreigners, for this reason, several ethnic studies were conducted from the sociological and anthropological perspectives. Among them, some scholars such as John T. Hitchcock, David Waters, Augusta Molnar, Michael Oppitz, Kawakita Jiro, James F. Fisher, M. Locomte-Tilouine, Gary Shepherd have contributed to explore about the Magars. Similarly, Nepalese scholars such as D.R. Regmi, Dor Bahadur Bista, Om Gurung, Janak Lal Sharma, Ramchandra Rai (rupabung), and other scholars have contributed to exploring the Magars. From the Magar community, Kesharjang Baralmagar (2050BS), M.S. Thapa (2059BS), Shyamu Thapa Magar

(2013), Min Bahadur Shris (2073 BS) have contributed to the study of the Magars. In those past contributions of scholars, this research work will be added as a brick because this work is also exploring the indigenous health care system, perception of ill-health, medication practices of the Magars from the sociological perspective.

Furthermore, this research work is related to health sociology and medical sociological studies. The research has explored the indigenous health care practices among the Magars, perception of ill-health and medication practices, changes in health practice, perception and knowledge regarding ill-health and medication of the Magars at the local level from the sociological perspective. Therefore, this research will contribute to the health or medical sociological field of sociology discipline.

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Annex -I: District-wise distribution of Magar Population & Mother Tongue in CBS 2011

S N	District	Mother Tongue			Position	Magar Population			Position
		Total	Male	Female		Total	Male	Female	
1	Taplejung	910	457	453	9th	1,272	646	626	13th
2	Panchthar	5,644	2,594	3,050	7th	6,368	2,961	3,407	7th
3	Illam	13,312	6,400	6,912	6th	15,076	7,272	7,804	6th
4	Jhapa	10,203	4,832	5,371	11th	17,784	8,380	9,404	11th
5	Morang	18,346	8,307	10,039	11th	25,126	11,554	13,572	12th
6	Sunsari	9,757	4,672	5,085	11th	15,300	7,354	7,946	15th
7	Dhankuta	15,187	6,849	8,338	4th	15,887	7,194	8,693	4th
8	Tehrathum	2,201	1,046	1,155	4th	2,451	1,160	1,291	9th
9	Sankhuwasabha	3,629	1,697	1,932	9th	5,298	2,505	2,793	12th
10	Bhojpur	6,288	3,002	3,286	5th	8,583	4,070	4,513	7th
11	Solukhumbu	1,621	819	802	9th	5,201	2,419	2,782	7th
12	Okhaldhunga	13,189	5,894	7,295	3rd	16,588	7,412	9,176	2nd
13	Khotang	9,090	4,274	4,816	3rd	10,317	4,879	5,438	6th
14	Udayapur	36,875	17,329	19,546	2nd	43,997	20,738	23,259	3rd
15	Saptari	1,524	713	811	6th	3,670	1,766	1,904	27th
16	Siraha	5,209	2,529	2,680	6th	6,978	3,379	3,599	20th
17	Dhanusa	7,097	3,464	3,633	6th	8,691	4,288	4,403	23th
18	Mahottari	12,199	5,946	6,253	4th	14,408	7,018	7,390	12th
19	Sarlahi	10,727	5,127	5,600	7th	15,296	7,297	7,999	15th
20	Sindhuli	32,100	15,398	16,702	3rd	44,146	21,327	22,819	2nd
21	Ramechhap	10,414	4,468	5,946	4th	22,544	9,962	12,582	4th
22	Dolakha	606	295	311	8th	3,076	1,485	1,591	11th
23	Sindhupalchok	367	207	160	12th	4,912	2,449	2,463	10th
24	Kabhrepalanchok	5,377	2,625	2,752	5th	14,572	7,040	7,532	5th
25	Lalitpur	6,833	3,525	3,308	5th	21,934	10,987	10,947	5th
26	Bhaktapur	1,502	766	736	5th	6,839	3,539	3,300	5th
27	Kathmandu	21,486	11,488	9,998	6th	70,083	36,340	33,743	5th
28	Nuwakot	524	252	272	8th	6,388	3,018	3,370	7th
29	Rasuwa	135	89	46	8th	571	299	272	8th
30	Dhading	6,461	2,246	3,515	5th	28,644	13,144	15,500	5th
31	Makwanpur	5,670	2,719	2,951	5th	18,945	9,069	9,876	6th
32	Rautahat	2,501	1,213	1,288	9th	5,096	2,508	2,588	26th
33	Bara	3,093	1,546	1,547	7th	6,758	3,335	3,423	24th
34	Parsa	581	288	293	12th	3,981	2,058	1,923	31st
35	Chitwan	9,321	4,276	5,045	7th	27,985	13,030	14,955	9th
36	Gorkha	12,656	5,586	7,070	3rd	31,390	13,879	17,511	4th
37	Lamjung	1,435	738	697	6th	3,757	1,841	1,916	10th
38	Tanahun	67,252	28,998	38,254	2nd	87,078	38,160	48,918	1st
39	Syangja	43,654	18,916	24,738	2nd	62,074	26,985	35,089	2nd
40	Kaski	10,782	5,256	5,526	3rd	42,547	20,504	22,043	4th

41	Manang	108	78	30	5th	203	140	63	8th
42	Mustang	315	182	133	5th	1,123	677	446	4th
43	Myagdi	2,516	1,132	1,384	2nd	44,846	20,027	24,819	1st
44	Parbat	6,004	2,664	3,340	2nd	16,068	7,220	8,848	3rd
45	Baglung	14,633	6,382	8,251	2nd	75,310	33,164	42,146	1st
46	Gulmi	5,474	2,538	2,936	2nd	58,079	25,099	32,980	3rd
47	Palpa	88,950	39,172	49,776	2nd	1,36,588	60,408	76,180	1st
48	Nawalparasi *	87,588	39,668	47,920	3rd	1,12,331	51,148	61,183	2nd
49	Rupandehi	36,810	16,825	19,985	5th	94,267	43,497	50,770	2nd
50	Kapilbastu	9,683	4,609	5,074	5th	20,285	9,521	10,764	9th
51	Arghakhanchi	2,671	1,264	1,407	2nd	35,584	15,834	19,750	3rd
52	Pyuthan	5,197	2,365	2,832	2nd	74,312	33,019	41,293	1st
53	Rolpa	23,855	10,936	12,919	2nd	97,011	44,309	52,702	1st
54	Rukum**	10,745	4,956	5,789	2nd	49,743	23,481	26,262	2nd
55	Sallyan	781	381	400	2nd	36,536	17,602	18,934	2nd
56	Dang	5,301	2,401	2,900	4th	75,131	34,722	40,409	3rd
57	Banke	4,644	2,125	2,519	6th	27,981	13,073	14,908	5th
58	Bardiya	3,003	1,453	1,550	5th	12,545	5,946	6,599	5th
59	Surkhet	24,456	11,768	12,688	2nd	66,219	31,666	34,553	2nd
60	Dailekh	4,018	1,908	2,110	2nd	24,213	11,816	12,397	5th
61	Jajarkot	360	175	185	3rd	15,487	7,752	7,735	4th
62	Dolpa	1901	898	1,003	4th	4,586	2,201	2,385	2nd
63	Jumla	33	26	7	6th	205	162	43	10th
64	Kalikot	410	228	182	2nd	530	311	219	10th
65	Mugu	16	14	2	6th	54	48	6	15th
66	Humla	54	48	6	5th	218	149	69	9th
67	Bajura	20	17	3	11th	134	78	56	15th
68	Bajhang	18	14	4	13th	210	121	89	10th
69	Achham	958	515	443	3rd	1,621	850	771	7th
70	Doti	2,085	1,070	1,015	3rd	7,211	3,684	3,527	6th
71	Kailali	10,938	5,463	5,475	5th	29,063	14,445	14,618	6th
72	Kanchanpur	7,430	3,648	3,782	7th	12,749	6,128	6,621	6th
73	Dadheldhura	1,603	791	812	3rd	5,181	2,548	2,633	6th
74	Baitadi	68	55	13	8th	308	193	115	13th
75	Darchula	126	80	46	6th	190	126	64	10th
Total		788,530	363,395	425,135	8th	1,887,733	874,416	1,013,317	3rd

* East Nawalparasi and west Nawalparasi districts after new constitution (2015) of Nepal

** East Rukum and west Rukum districts after new constitution (2015) of Nepal

Source: CBS 2011/ Table developed by researcher, May 2015.

Annex - II: Approval Letter of Nepal Health Research Council (NHRC)



Government of Nepal
Nepal Health Research Council (NHRC)

Estd. 1991



Ref. No.:

47

26 July 2015

Mr. Bishnu Kumar Sinjali

Principal Investigator
Tribhuvan University
Kirtipur, Nepal

Ref: **Approval of Research Proposal** entitled **Concept of health, illness and practices of medication in socio-cultural context: A study of the indigenous Magar community of surroundings Tamkikot hill of Western Nepal**

Dear Mr. Sinjali,

It is my pleasure to inform you that the above-mentioned proposal submitted on 06 March 2015 (**Reg. no. 53/2015** please use this Reg. No. during further correspondence) has been approved by NHRC Ethical Review Board on 22 July 2015.

As per NHRC rules and regulations, the investigator has to strictly follow the protocol stipulated in the proposal. Any change in objective(s), problem statement, research question or hypothesis, methodology, implementation procedure, data management and budget that may be necessary in course of the implementation of the research proposal can only be made so and implemented after prior approval from this council. Thus, it is compulsory to submit the detail of such changes intended or desired with justification prior to actual change in the protocol.

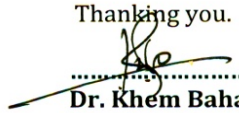
If the researcher requires transfer of the bio samples to other countries, the investigator should apply to the NHRC for the permission.

Further, the researchers are directed to strictly abide by the National Ethical Guidelines published by NHRC during the implementation of their research proposal and submit progress report and full or summary report upon completion.

As per your research proposal, the total research amount is **Self-funded** and accordingly the processing fee amounts to **NRs. 1,000.00**. It is acknowledged that the above-mentioned processing fee has been received at NHRC.

If you have any questions, please feel free to contact the Ethical Review M & E section of NHRC.

Thanking you.


.....
Dr. Khem Bahadur Karki
Member-Secretary

Annex-III: Ethnicity/Caste-wise Population Distribution of Syangja District

SN	Ethnicity/Caste	CBS 2011				CBS 2001			
		%	Total	Male	Female	%	Total	Male	Female
1	Brahman – Hill	30.881	89,291	38,837	50,454	32.884	104,348	46,797	57,551
2	Magar	21.468	62,074	26,985	35,089	21.192	67,245	30,809	36,436
3	Chhetree	11.526	33,327	14,254	19,073	11.172	35,452	15,648	19,804
4	Gurung	8.966	25,926	11,416	14,510	9.986	31,687	14,304	17,383
5	Kami	8.022	23,195	9,993	13,202	6.671	21,167	9,593	11,574
6	Sarki	4.032	11,658	5,029	6,629	3.308	10,497	4,788	5,709
7	Damai/Dholi	3.711	10,731	4,613	6,118	3.235	10,266	4,693	5,573
8	Newar	3.332	9,635	4,237	5,398	3.328	10,559	4,842	5,717
9	Thakuri	2.454	7,097	3,043	4,054	2.478	7,863	3,566	4,297
10	Gharti/Bhujel	2.429	7,022	3,068	3,954	2.221	7,049	3,183	3,866
11	Musalman	0.687	1,986	936	1,050	0.578	1835	886	949
12	Dashnami/ Sanyasi	0.574	1,659	706	953	0.747	2371	1,063	1,308
13	Kumal	0.563	1,629	744	885	0.451	1,431	686	745
14	Majhi	0.286	828	404	424	0.332	1,054	516	538
15	Khawas	0.162	467	194	273	0.000	-	-	-
16	Tharu	0.120	346	252	94	0.075	239	179	60
17	Tamang	0.094	271	133	138	0.065	205	148	57
18	Bote	0.091	263	130	133	0.001	2	0	2
19	Rai	0.088	254	135	119	0.049	155	89	66
20	Badi	0.056	162	79	83	0.010	31	14	17
21	Brahman – Tarai	0.049	142	59	83	0.004	12	11	1
22	Gaine	0.046	133	54	79	0.043	136	61	75
23	Kathbaniyan	0.037	107	56	51	0.024	76	51	25
24	Hajam/Thakur	0.031	90	50	40	0.005	15	11	4
25	Thakali	0.024	70	33	37	0.024	77	38	39
26	Sunuwar	0.021	61	31	30	0.000	0	0	0
27	Yadav	0.017	50	34	16	0.018	58	35	23
28	Teli	0.013	38	25	13	0.049	157	33	124
29	Limbu	0.012	36	20	16	0.014	45	35	10
30	Haluwai	0.011	31	17	14	0.000	0	0	0
31	Kurmi	0.010	30	18	12	0.002	7	5	2
32	Dura	0.009	27	12	15	0.002	5	1	4
33	Kalwar	0.008	22	12	10	0.010	32	19	13
34	Koiri/Kushwaha	0.006	17	6	11	0.009	28	8	20
35	Dhanuk	0.005	14	5	9	0.003	8	7	1
36	Sherpa	0.005	14	8	6	0.008	24	14	10
37	Bangali	0.005	14	11	3	0.000	0	0	0
38	Dusadh/ Pasawan/Pasi	0.004	13	4	9	0.001	3	1	2
39	Ghale	0.004	13	3	10	0.000	0	0	0
40	Musahar	0.004	11	2	9	0.002	6	6	0
42	Sonar	0.004	11	3	8	0.000	0	0	0
43	Sudhi	0.004	11	7	4	0.000	1	0	1
44	Others	0.040	115	60	55	0.626	1,986	902	1,084
45	Dalit Others	0.008	24	15	9	0.257	815	364	451
46	Terai Others	0.062	180	80	100	0.000	0	0	0
47	Undefined Others	0.014	40	15	25	0.118	373	213	160
48	Foreigner	0.004	13	5	8	0.000	0	0	0
	Total	100	289,148	125,833	163,315	100	317,320	143,619	173,701

Source : CBS 2001, CBS 2011

Annex- IV: Health Care Provisions in Constitution of Nepal

The Nepalese health care services, health rights, health care settings are under the constitution of Nepal. Nepal has a long history of the construction of constitutions and replaced by a new constitution. In Nepal, codified laws were written in the medieval period (by kingdom Jayasthiti Mall). Prime Minister *Junga Bahadur Rana* in 1953/4 issued *Muluki Ain* in the *Rana* regime. In 1948 (2004 BS), the first constitution (Nepal Government Act-2004 BS) was released by Mr. Padma Shamsher Rana on 26 Jan, 1948 from the *Rana* Dynasty which had 6 parts, 68 articles and 2 schedules. Later on, after the fall of the *Rana* regime, in 1951(2007BS), Nepal has released another interim constitution of Nepal (Interim Nepal Government Act- 2007BS)which was promulgated from the King Tribhuvan on 30 March 1951 having 7 parts, 73 articles and 3 schedules. The elected government gave another constitution in 1959 (2015 BS) called 'Constitution of the Kingdom of Nepal -1959' which was promulgated on 12 February 1959 consisting 10 parts, 77 articles and 3 schedules.

King Mahendra introduced *Panchayat* system in Nepal and released the Constitution of Nepal 1962 (2019BS) on 16 December 1962 (01 Paush, 2019BS) which had 20 parts, 97 articles and 6 schedules. In 1990, the first *Jana Andolan* brought multi-party democracy back to Nepal and promulgated 'Constitution of the Kingdom of Nepal, 1990 (2047 BS) on 09 November 1990. Similarly, the Maoist people's war and democracy movements of 2006 brought another revolution in Nepalese politics. Then, the 'Nepal Interim Constitution-2007 (2063BS)' was promulgated on 15 January 2007 which had 25 Parts, 167 articles and 4 schedules (https://en.wikipedia.org/wiki/Constitution_of_Nepal -Visited on 19 Aug 2018). And recently, we have the 'The Constitution of Nepal-2015 (2072BS)' which was promulgated on 20 September 2015. In the past constitutions and codified laws, there were few arrangements about the health care, health care system of Nepal. In the interim constitution of 2007 (2063BS), for the first time, health is mentioned as the fundamental right in article 16. Although, there were several legislation arrangements of health care systems in the past constitutions, in this section, the arrangement of the 'The constitution of Nepal-2015) is discussed.

Nepalese Constitution 2015 (2072 BS) is the latest constitution of the nation. The constitution has provided the arrangement of rights to live with dignity in article 16 which is essential to be healthy for a person and personal dignity could give head rise in the society to the respected person and give moral and empower to become healthy. In article 35, 'right relating to health' is described as follow:

35. Right relating to health: (1) Every citizen shall have the right to free basic health services from the State, and no one shall be deprived of emergency health services.

(2) Every person shall have the right to get information about his or her medical treatment.

(3) Every citizen shall have equal access to health services.

(4) Every citizen shall have the right of access to clean drinking water and sanitation. (pp. 14-15).

In this article, the constitution has arranged free basic health services, equal excess to health service, right to get information and access to clean drinking water and sanitation for the Nepalese citizens which is so much progressive in the document. Similarly, Article 30 has arranged the 'Right to clean environment' for the public and in sub-article 30 (1) mentioned as "Every citizen shall have the right to live in a clean and healthy environment" (p. 13). In article 36, Constitution has arranged right related to food and sub-article 30 (1) stated as "Every citizen shall have the right relating to food" and sub-article 36(2) stated as "Every citizen shall have the right to be safe from the state of being in danger of life from the scarcity of food" (p. 15). In article 37 talks about the 'Right to housing', proper housing will be required for a healthy environment for family and person for better life and in sub-article 37 (1) has mentioned as, "Every citizen shall have the right to an appropriate housing" (p.15). In such a way, in article 38 'rights of women' has mentioned and their health provisions are mentioned in sub-article 38 (2) as, "Every woman shall have the right to safe motherhood and reproductive health" and sub-article 38 (5) also ensuring the health opportunity for women and stated as, "Women shall have the right to obtain special opportunity in education, health, employment and social security, on the basis of positive discrimination" (p. 15). Similarly, article 39 talks about the 'Right of the Child' their health rights are mentioned in sub-article 39(2) as, "Every child shall have the right to education, health, maintenance, proper care, sports, entertainment and overall personality development from the families and the State" (p.16).

In the constitution, Article 51 has mentioned the 'policies of the state' and in sub-article 51 (h) has stated the "Policies relating to basic needs of the citizens" where health policies are also included. In sub-article 51 (h) (5-10 and 15) are mentioned as follows:

Article 51 (j) (5) to keep on enhancing investment necessary in the public health sector by the State in order to make the citizens healthy, (6) to ensure easy, convenient and equal access of all to quality health services, (7) to protect and

promote health systems including *Ayurveda*, as a traditional medical system of Nepal, natural therapy and homeopathy system, (8) to make private sector investment in the health sector service-oriented by regulating and managing such investment, while enhancing the State's investment in this sector, (9) to focus on health research and keep on increasing the number of health institutions and health workers in order to make health services widely available and qualitative, (10) to increase average life expectancy by reducing maternal and infant mortality rate, while encouraging family planning for population management on the basis of Nepal's capacity and need, (15) to arrange for access to medical treatment while ensuring citizen's health insurance. (pp. 25 -26).

Beside this, the Federal government has kept health rights which are mentioned in schedule - 5, 'list of federal power' in SR 16 and stated as "Health policies, health services, health standards, quality and monitoring, national or specialized service providing hospitals, traditional treatment services and communicable disease control" (p.173). In Schedule -6, it is mentioned as 'list of state power' and here, in SR 9 'health service' has mentioned as the power of the state in health provision. The concurrent power of federal and state has stated on Schedule -7 and "Drugs and pesticides" and "planning, family planning and population management" (p.177) has been stated regarding heal provision through concurrent power or federal and state government. In schedule-8, a 'list of local-level power' has been mentioned wherein serial number nine 'Basic health and sanitation' power has been given to the local government. In such a way, in schedule-9, the 'list of concurrent power of federal, state and local level' government has been stated, where health has been kept in concurrent power of three-level governments (Government of Nepal, 2072 BS).

Annex- V: Health Policy of Nepal

Nepal government has passed 'Rashtriya Swasthya Niti-2071 BS' (National Health Policy) and revoked National health policy- 2048 BS), which is published in Annual Report 2071/72 (2014/2015) of GoN, MoH, Department of Health Services (DoHS). In the national health policy-2071BS, article 5.1 has been described **Vision** as, "All Nepalese citizens would be able to live productive and quality life; being physically, mentally, socially, and emotionally healthy" (p. iv). Article 5.2 mentioned **Mission** as "Ensure the fundamental right of citizens to remain healthy through a strategic collaboration among service provider, beneficiaries, and stakeholders and optimum utilization of available resources." and article 5.3 stated goal of national health policy as "To ensure health for all citizens as a fundamental human right by increasing access to quality health services through a provision of just and accountable health system" (p v). Article 6 has stated policies in of the national health policy-2071BS which are divided into sub-article 6 (1) - 6(14) and stated as:

1. To make available in an effective manner the quality health services, established as a fundamental right, ensuring easy access within the reach of all citizens (universal health coverage) and provision of basic health services at free of cost.
2. To plan produce, acquire, develop, and utilize necessary human resources to make health services affordable and effective.
3. To develop the Ayurvedic medicine system through the systematic management and utilization of available herbs in the country as well as safeguarding and systematic development of other existing complementary medicine systems.
4. To aim at becoming self-sufficient in quality medicine and medical equipment through effortless and effective importation and utilization with emphasis on internal production.
5. To utilize in policy formulation, program planning, medical and treatment system, the proven behaviours or practices obtained from researchers by enhancing the quality of research to international standard.
6. To promote public health by giving high priority to education, information, and communication programs for transforming into practice the access to information and messages about health as a right to information.
7. To reduce prevalence of malnutrition through promotion and usage of quality healthy foods.
8. To ensure availability of quality health services through competent and accountable mechanism and system for coordination, monitoring and regulation.
9. To ensure professional and quality service standard by making health related professional councils capable, professional, and accountable.
10. To mainstreaming health in every policy of state by reinforcing collaboration with health-related various stakeholders.
11. To ensure the

right of citizens to live in a healthy environment through effective control of environmental pollution for protection and promotion of health. 12. To maintain good governance in the health sector through necessary policy, structure, and management for delivery of quality health services. 13. To promote public and private sectors partnership for systematic and quality development of the health sector. 14. To increase the investment in the health sector by the state to ensure quality and accessible health services and to provide financial security to citizens for medical cost and as well as effectively utilize and manage financial resources obtained from the private and non-government sector (DoHS, 2016, pp. v-vi).

Annex- VI: Nepal Stands in Terms of Achieving the MDGs

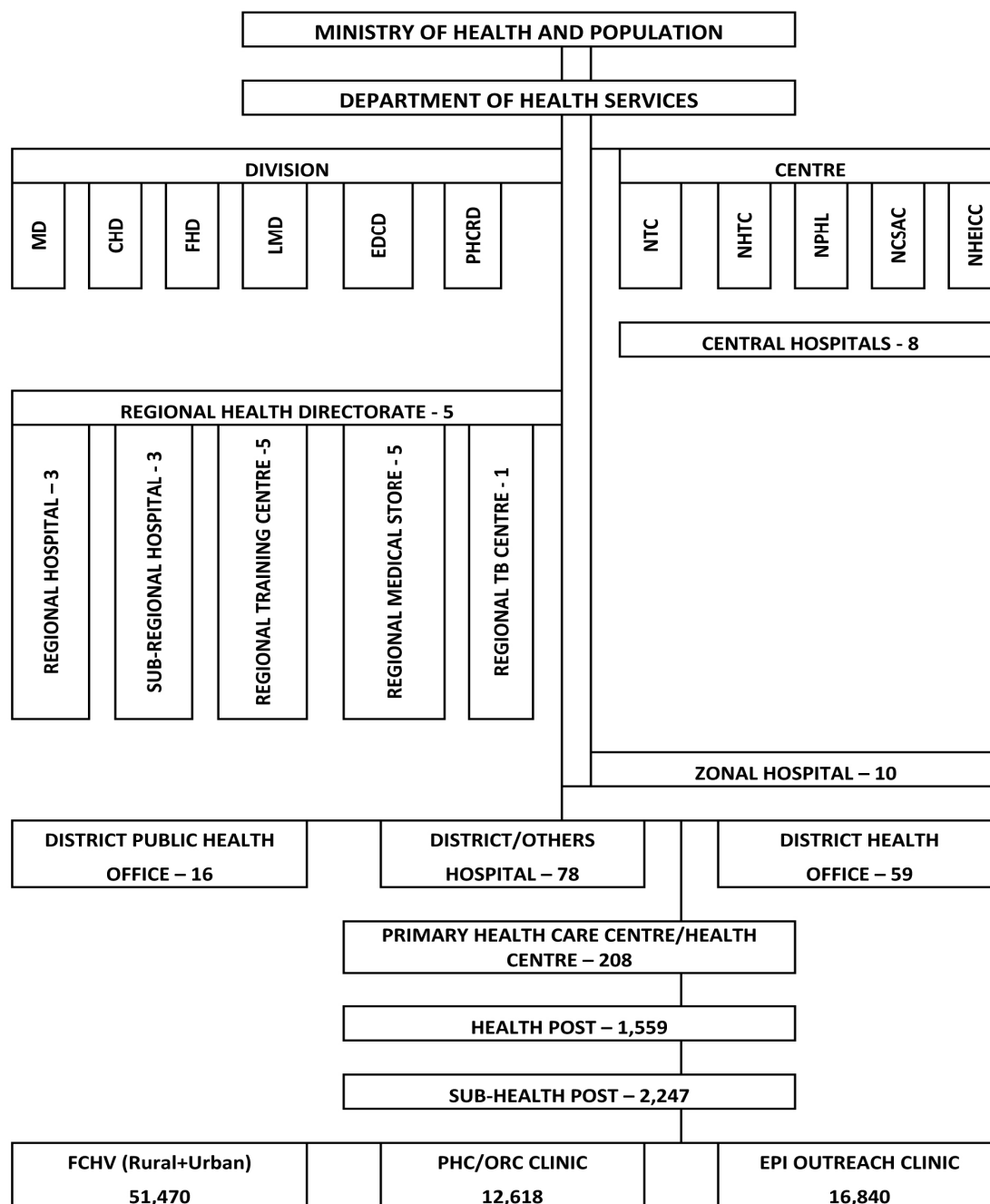
Nepal stands in terms of achieving the MDGs

Goal	Likelihood of achievement				Status of supportive environment				
	Achieved	Likely	Potential ly Likely	Unlikely	Lack of data	Strong	Fair but Improvi	Weak	
1. Eradicate extreme poverty and hunger		√							
1 (a) Reduce extreme poverty by half						√			
1 (b) Full and productive employment for all			√				√		
1 (c) Reduce extreme hunger		√			√				
2. Achieve universal primary education			√		√				
3. Gender equality and empowerment of women				√			√		
4. Reduce child mortality		√				√			
5. Improve maternal health		√				√			
5 (a) Reduce maternal mortality by three quarters	√					√			
5 (b) Achieve universal access to reproductive health		√				√			
6. Combat HIV/AIDS , malaria, and TB		√				√			
6 (a) Have halted and begun to reverse the spread of HIV/AIDS		√				√			
6 (b) Achieve universal access to treatment for HIV/AIDS		√				√			
6 (c) Have halted and begun to reverse the incidence of malaria and other diseases	√					√			
7. Ensure environmental sustainability									
7 (a) Reverse loss of forest		√					√		
7 (b) Reduce Biodiversity Loss		√					√		
7 (c) Halve proportion of people without sanitation			√				√		
7 (d) Improve lives of slum dwellers					√			√	

Source: <https://www.np.undp.org/content/nepal/en/home/post-2015/mdgoverview.html> , downloaded date 25 Jan 2020

Annex- VII: Organogram of the Department of Health Services and Functions

1. Organogram of Department of Health Services (DoHS)



Source: DOHs, Annual Report 2070/71 (2013/2014), p. 4.

In health sector, the public service delivery outlets in the country include 2,247 SHPs, 1,559 HPs, 208 PHCC/HC, 78 district/other hospitals, 10 Zonal hospitals, 3 sub-regional hospitals, 3 regional hospitals, and 8 central level hospitals (DoHS, 2015 p. 4).

2. The **Major functions** of Department of Health Services (DoHS) include:

- Provide GoN with necessary technical advice in formulating health related policies, develop and expand health institutions established in line with these policies;
- Determine requirement of human resource for health institutions and develop such human resource by preparing short and long term plans;
- Manage procurement and supply of drugs, equipment, instruments and other logistics at regional, district and below levels;
- Co-ordinate the activities and mobilize resources in the implementation of approved programs;
- Manage the immediate solution of problems arising from natural disasters and epidemics;
- Establish relationships with foreign countries and international institutions with the objective of enhancing effectiveness and developing health services and assist the Ministry of Health and Population in receiving and mobilizing foreign resources by clearly identifying the area of cooperation;
- Create a conducive atmosphere to encourage the private sector, non-governmental organizations and foreign institutions to participate in health services, maintain relation and coordination, control quality of health services by regular supervision and monitoring;
- Manage free medication & treatment for very severe disease: Cancer, Heart, Alzaimers and Parkinsons, Head and Spinal injuries and Renal failure (Kidney Disease) to impoverished Nepalese citizens;
- Manage information systems regarding health facilities, health services, logistics, training and finance to support planning, monitoring, and evaluation of health programs,
- Systematically maintain data, statements and information regarding health services, update and publish them as required;
- Financial management of DoHS, RHDs, D/PHOs and settlement of irregularities (DoHS, 2015 p. 3).

Annex-VIII: Medical Colleges and Teaching Hospitals of Nepal

SN	MEDICAL COLLEGE NAME	TYPE	LOCATION
1	Institute of Medicine (TU)	Public	Kathmandu
2	B.P. Koirala Institute of Health and Sciences (BPKIHS)	Public	Dharan
3	Manipal College of Medical Sciences	Private	Pokhara
4	College of Medical Sciences	Private	Chitwan
5	Nepal Medical College	Private	Jorpati, Ktm
6	Kathmandu Medical College	Private	Sinamangal Ktm
7	Nepalgunj Medical College	Private	Nepalganja
8	Universal College of Medical Science	Private	Bhairahawa
9	Kathmandu University, School of Medical Science	Private	Dhulikhel
10	National Medical College	Private	Birgunja
11	Janaki Medical College	Private	Janakpur
12	Nobel Medical College	Private	Biratnagar
13	Kist Medical College	Private	Kathmandu
14	Lumbini Medical College & Research Center Pvt. Ltd.	Private	Palpa
15	Chitwan Medical College	Private	Chitwan
16	Patan Academy of Health Sciences	Public	Lalitpur
17	Gandaki Medical College	Private	Pokhara
18	NAIHS College of Medical Sciences	Army	Kathmandu
19	National Academy of Medical Sciences (NAMS)	Public	Kathamandu

Source: <http://dohs.gov.np/hospitals/medical-colleges/> (Retrieved date 17 August 2018).

Annex-IX: Indigenous Knowledge Regarding Health, Illness and Healings

The Indigenous knowledge is reflected into culture and language. The linguistic variation differs in describing indigenous skill and knowledge. And language is a part of culture. The local language variation carries the indigenous knowledge. The lost of language without written several literature, the hidden knowledge within language died. Therefore, the written form of language is could explore the indigenous knowledge and skills, worldviews regarding to health, illness and medication practices. Here, some Magar words related with health, illness and medications are collected during the field visit.

6.3.2 Some IKS regarding Health and Wellbeing Preserved in Magar Language

The indigenous knowledge toward ill-health, medication practices are based on their ancestral mother tongue and culture. The classification of illness, perception of health care and public health, epidemiology of illness, understanding body and body parts (Anatomy and physiology), preventive measures and healings and other aspects of traditional health care or ethno-medicine are reflected into their own language. Here, some data are collected in the field through key informant interview, focus group discussion and observation from the field which is presented category-wise in this sub-chapter.

6.3.2.1 Indigenous Nomenclature about Anatomy and Physiology

To understand illness, health and healing; knowledge about anatomy and physiology is essential. Therefore, here is mentioned basic anatomy and physiology word in Magar language. In General, Anatomy is related with study of about structures and system of the organs, tissues, cells or biological systems and physiology is related with study of the function of the organs, tissues cells or biological systems of the body.

The Magar language is endangered situation because government don't invest on it. There isn't formal education conducted in this language by the government or Magar themselves. Majority speakers of this language are in remote area; and they are economically-socially marginal with hardship condition. That's why they are unable to invest in their own language. There isn't formal education system regarding to health and medicine in Magar language, therefore practice of Magar words related to health and illness is limited. In another aspect, most of Magar are migrating from their own ancestor land and loosing language. Media of elite and ruling class, Government's education system, Sanskritizaion, Indianization,

Westernization and Migration are also going to kill Magar language. The words related anatomy and physiology are presented as follows:

6.3.2.1.1 External Human Body Parts

lu /lu/, **milu** /milu/ ‘head’

nger /ŋer/, **menger** /meŋer/ ‘mouth’

taanhaan /tahan/ ‘forehead’

kep /kep/, **mekep** /mekep/ ‘ear’

nhaa/n^ha/, **minhaa** /min^ha/ ‘nose’

mik/mik/, **mimik** /mimik/ ‘eye’

ghoyok /g^hojok/ ‘chin’

dungaa /duŋa/, **midungaa** /miduŋa/ ‘neck’

kithara/kit^hΛrΛ/, **michhaati** /miʃ^hati/ ‘chest’

dut /dut/ ‘breast’

kum /kum/ ‘shoulder’

hut /hut/, **mihut** /mihut/ ‘hand’

mipaakhura /mipak^hurΛ/ ‘arm’

bauthaa /bΛw^ha/ ‘thumb’

chhyaang /ʃ^hjaŋ/ ‘finger, toes’

mirkin /mirkin/ ‘nail’

tuk /tuk/, **mituk** /mituk/ ‘abdomen, stomach’

mepong /mepoŋ/ **mhaakcha mituk**/m^hakʃ^hΛ mituk/ ‘lower abdomen’

do /do/, **medo** /medo/ ‘penis’

porot /porot/, **meporot** /meporot/ ‘vagina’

berhwa /ber^hwa/, **chorhyaa** /ʃor^hja/ ‘anus, rectum’

chardi /ʃardi/ ‘back body’

putha /put^hΛ/ ‘buttock, hips’

gaahaa /gaha/ ‘thigh’

mighundaa /mig^hunda/ ‘knee’

phargyaan /p^hΛrgjan/ ‘calf’

hil /hil/, **mihil** /mihil/ ‘leg, foot’

thap/t^hΛp/, **paitalaa** /pΛjtΛla/ ‘sole of foot, foot’

buligaanthetaa /buligan^ha/, **goligaanthetaa** /goligan^ha/ ‘ankle’

gaanthetaa /gant^ha/ ‘joints’

syaakho /sjak^ho/ **michhaalaa** /miʃ^hala/ ‘skin’

chhaam /tʃʰam/, **michhaam** /miʃʰam/ ‘hair’

6.3.2.1.2 Digestive System

nger /ŋer/, **menger** /meŋer/ ‘mouth’

let/let, **melet** /melet/ ‘tongue’

syak/sjak, **misyak** /misjak/ ‘tooth’

ghonkra /gʰonkrʌ/ ‘pharynx, throat’

jyaat dhongra /dʒjat dʰoŋra/ ‘oesophagus, food pipe’

tuk /tuk/, **mituk** /mituk/ ‘abdomen, stomach’

pitta saanaa /pittʌ sana/ ‘gall bladder’

misin /misin/, **mikalejo** /mikʌledʒo/ ‘liver’

mhaarcha mekhe /mʰarʃʌ mekʰe/ ‘small intestine’

karhaangcha mekhe /kʌrʰaŋʃʌ mekʰe/ ‘large intestine’

berhwaa /berʰwa/, **chorhyaa** /tʃorʰja/ ‘anus, rectum’

6.3.2.1.3 Musculo-skeletal System

misya /misja/ ‘muscle’

rhus /rʰus/, **mirhus** /mirʰus/ ‘bone’

khappar /kʰʌppʌr/ ‘skull’

6.3.2.1.4 Respiratory System

nhaa/nʰa/, **minhaa** /minʰa/ ‘nose’

ghonkra /gʰonkrʌ/ ‘pharynx, throat’

saawatghonkra /sawʌt gʰonkrʌ/ ‘larynx’

misuhu nalki /misuhu nʌlki/ ‘trachea’

miphoksaang anch misuhu dhonraa/mipʰoksaŋ ʌŋʃ misuhu dʰonra/ ‘bronchus’

miphoksyaa /mipʰoksja/ ‘lung’

6.3.2.1.5 Circulatory System

mihi/mihi/, **hyu** /hju/ ‘blood’

mihi nasaa /mihi nʌsa/ ‘vein, artery’

mihi dhongra /mihi dʰoŋra/ ‘blood vessels’

gin /gin/, **migin** /migin/ ‘heart’

6.3.2.1.6 Urinary System

mirgaula /mirgawl/ ‘kidney’

rhos dhongra /r^hos d^hoŋr/ ‘ureter’

rhosmim /r^hosmim/ ‘rinary bladder’

rhos kheucha dhongra /r^hos k^heuf^h d^hoŋr/ ‘urethra’

6.3.2.1.7 Nervous System

milukdi /milukdi/, **milukdu** /milukdu/, **gidi** /gidi/ ‘brain’

5.5.2.1.8 Endocrine system

melokmim /melokmim/ ‘ovary’

gerek/gerek/, **gere** /gre/ ‘testis’

6.3.2.1.9 Reproductive System

Male (internal)

gerek/gerek/, **gere** /gre/ ‘testis’

nghyaan /ŋ^hjan/ ‘spermatozoid’

nghyaa hwacha dhongra /ŋ^hja hwa^h d^hoŋr/ ‘spermatic cord, vas difference’

nghyaandi saanaa /ŋ^hjandi sana/, **phusi saanaa** /p^husi sana/ ‘seminal vesicle’

khewhakchadhongra /k^hew^hakt^h d^hoŋr/ ‘ejaculatory duct’

mastap granthi /m^hstap gr^hanthi/ ‘prostate gland’

rhos kheucha dhongra /r^hos k^heuf^h d^hoŋr/ ‘urethra’

Male (External)

gerekmim /gerekmim/ ‘scrotum’

do /do/, **medo** /medo/ ‘penis’

do midum /do midum/ ‘glans penis’

do midungaa /do miduŋa/ ‘neck of penis’

do syaakhu /do sjak^hu/, **do michhaalaa** /do mi^hhala/ ‘prepuce’

Female (Internal)

melokmim /melokmim/ ‘ovary’

melok hwacha dhongra /melok w^haf^Λ d^hoŋɾΛ/ ‘fallopian tube’

bhaandar /b^handΛɾ/, **mibhaandar** /mib^handΛɾ/, **garbhaim** /gΛɾb^hΛ im/ ‘uterus’

porot /porot/, **meporot** /meporot/ ‘vagina’

Female (External)

mimuji /mimudʒi/, **muji** /mudʒi/ ‘vulva’

tisi /tisi/, **misihin** /misihin/ ‘clitoris’

meporot baahiring burlin /meporot bahiriŋ burlin/ ‘labia majora’

meporot bhitri burlin /meporot b^hiri burlin/ ‘labia minora’

dut /dut/ ‘breast’

6.3.2.1.10 Lymphatic System

Lymphatic system is related with immune system of the body and it protects to the body. In Magar language there isn't found words related to the lymphatic system in deep and vast as like in English due to decaying indigenous knowledge and language.

phiyo /p^hijo/ ‘spleen’

6.3.2.2 Verbs Related to Illness and Healings

In Magar Language verbs related to the illness, health and healing is used to express about illness, types of illness, illness grade and quality or quantity of illness. Verbs in Magar language related health and illness, healings are presented as follows:

osotke /osotke/ ‘to itch, itching’

chhaake /tʃ^hake/ ‘to become ill’

gepke /gepke/ ‘to become heal, better’

jherke /dʒ^herke/ ‘to become healthy, better’

bikke /bikke/ ‘to hurt’

rutke /rutke/ ‘to become thin’

sepke /sepke/ ‘to become thin like leaf’

chheriske /tʃ^heriske/ ‘loose motion, watery defecation’

archaa sutke /Λɾtʃa sutke/ ‘to inject’

aanghake /aŋ^hΛke/ ‘? a kind of fear condition and action due to water or air’

chaangke /tʃʰaŋke/ ‘? to do force for deification, urination or child birth in giving birth’

mhungke /mʰuŋke/ ‘to be tired’

mhaangke /mʰaŋke/ ‘to feel dizzy’

mhaangaakke /mʰaŋakke/ ‘to cause to feel dizzy’

huske /huske/ ‘to pull out (self)’

hutke /hutke/ ‘to pull out’

phetke /pʰetke/ ‘to keep heavy weight over the someone’

diske /diske/ ‘watery’

jihike /dʒihike/ ‘cramp (pain at dysentery, abdomen diseases)’

chyaske /tʃjaske/ ‘to become small scratch, tear’

bharaakke /bʰʌrakke/ ‘to become snap’

ngetke /ŋetke/ ‘to press to makethe pus come out’

riske /riske/ ‘to become dirt’

reske /reske/ ‘to bath’

hurke /hurke/ ‘to wash’

jhongokke /dʒʰoŋokke/ ‘to make neat and clean’

hupke /hupke/ ‘to cover’

molke /molke/ ‘to smear’

molokke /molokke/ ‘to mix’

gyaake /gjakke/ ‘becoming reddish color’

wokke /wokke/ ‘to vomit’

chuhuke /tʃuhuke/ ‘to cough’

chhiske /tʃʰiske/ ‘to sneeze’

mijaa pitke /midʒa pitke/ ‘to do induced abortion’

tuk buke /tuk buke/ ‘to become pregnant’

burukke /burukke/ ‘cause to shivering’

mihi aanke /mihi anke/ ‘bleeding’

cheke /tʃeke/ ‘to cut’

rupke /rupke/ ‘to sew’

joske /dʒoske/ ‘to burn’

dheske /dʰeske/ ‘to become fate, obesity’

6.3.2.3 Nomenclatures of Illness and Disease

Many words of Magar language regarding to illness, ill-health and disease are forgotten by the Magars due to unused of the words and lack of practice. The indigenous knowledge about the illness and health of Magars never taught in School or University; and always away from mainstream of Nepal. The government and elites of Nepal always discourage to use and practice Magar language, therefore several words have already disappeared. Some remainder Magar words regarding to illness and disease presented as follows:

6.3.2.3.1 Some Magar Words Related to Symptoms

lu bikke /lu bikke/, **lu bihaakke**/lu bihakke/ ‘headache’

mhaangke /m^haŋke/ ‘dizziness’

haamke /hamke/ ‘yawning’

chhiske /tʃ^hiske/, **chhisaakke** /tʃ^hisakke/ ‘sneezing’

minaap/minap/, **minhaap** /m^hinap/ ‘mucus discharge from nose’

mik maaraahaake /mik marahake/ ‘insomnia’

jyaake gin maaraahake /dʒjake gin marahake/ ‘loss of appetite’

jyaacha majaapke /dʒjatʃΛ madʒapke/ ‘loss of appetite’

mhungke/m^huŋke/, **mhung raahaake** /m^huŋ rahake/ ‘lethargy’

chuhuke /tʃuhuke/ ‘cough’

bikke /bikke/ ‘to hurt’

bihakke /bihakke/ ‘to cause pain’

jurungjurungjatke /dʒuruŋ dʒuruŋ dʒatke/ ‘chills’

burukke /burukke/ ‘shivering’

aarhenke /ar^henke/ ‘numbness of legs, numbness’

tuk jihike /tuk dʒihike/ ‘abdominal cramps (specially in dysentery)’

tuk bikke /tuk bikke/ ‘abdominal pain’

sepchai aanke/sepʃΛj anke/, **rutke** /rutke/ ‘lean and thin’

hijyok /hidʒjok/, **mihi aanke** /mihi anke/ ‘bleeding’

chheriske /tʃ^heriske/ ‘loose motion, diarrhoea’

bhes naamke /b^hes namke/ ‘bad smelling of passed wind from the anus’

namchos kheuke /mΛmʃos k^heuke/ ‘sweating’

jumhaakke /dʒum^hakke/ ‘feeling cold’

khaanke /k^hanke/ ‘feeling hot’

6.3.2.3.2 Magar Words Regarding Illness and Disease

- sikhan**/sik^hʌn/, **jabe** /dʒʌbe/ ‘allergic rashes, allergy’
- ukuj** /ukudʒ/ ‘eczema’
- taahaan**/tahan/, **taanhaan** /tan^hʌn/ ‘ring worm’
- mhaan** /m^hʌn/ ‘wound’
- karhaan-mhaan** /kʌr^hʌn-m^hʌn/ ‘A kind of skin infection like boils’
- jumhaan** /dʒum^hʌn/ ‘boil’
- karhangcha jumhaan** /kʌr^hʌŋtʃʌ dʒum^hʌn/ ‘big boils’
- gwaa jumhaan** /gwa dʒum^hʌn/ ‘carbuncles, small boils’
- checha mhaan** /tʃeʃʌ m^hʌn/ ‘cut wound’
- luto** /luto/ ‘scabies’
- byangdar** /bjaŋdʌr/ ‘measles’
- chhiske** /tʃ^hiske/ ‘sneezing’
- chuheke** /tʃuheke/ ‘coughing’
- kausul**/kʌusul/, **kapsul** /kʌpsul/ ‘asthma, shortness of breath, COPD’
- mingya aanke**/miŋʃʌ anke/, **bhiske** /b^hiske/ ‘a kind of disease of fear (specially in children)’
- saato aancha** /sato aŋʃʌ/ ‘a kind of disease of fear (specially in children, indigenous)’
- namsu pahiske** /nʌmsu pʌhiske/ ‘disease like appendicitis’
- haija** /hʌjdʒʌ/ ‘cholera’
- maasi** /masi/ ‘dysentery’
- sul** /sul/ ‘worm infestation’
- tus** /tus/ ‘giardiasis’
- kuphat** /kup^hʌt/ ‘disease like pneumonia, high fever, cough, chest pain, respiratory problems’
- begaar** /begaar/ ‘food poisoning’
- suke begaar** /suke begaar/ ‘becoming lean and thin due to unknown disease’
- khapate** /k^hʌpʌte/ ‘tuberculosis’
- mos** /mos/ ‘repeated abortion & infertility’
- moch** /moʃ / ‘Moch becomes two types, one in pregnancy - repeated abortion or & infertility, Second after birth- possibility of infant mortality. In such a condition they avoid banana, even do not touch, and in infant moch, the sarki ethnic tie cow skin at arms or limbs and after few days or months open the cow's skin and took with him and moch cure in infants (belief)’
- gaano** /gano/ ‘gastritis, gastric ulcers’
- gaanogolaa** /ganogola/ ‘cholesteasis (stone at gall bladder)’
- sutak baayugolaa** /sutʌk bajugola/ ‘a kind of abdominal disease’

chherautyaa /tʰeɾɐʌtʃa/ diarrhoea

raanghaan /raŋʰan/ ‘arthritis, rheumatic arthritis’

lakhuwa /lakʰuwa/ ‘paralysis, weakness of limbs’

kharjulo /kʰɐɾdʒulo/ ‘disorder of hot and cold (indigenous classification)’

somokke /somokke/ ‘a kind of disease with diarrhoea (green diarrhoea), vomiting in children’ caused by stream/river, Bar Pipal or walking outside the house

thunelo /tʰunelo/ ‘breast abscess’

harsaa /hɐɾsa/ ‘haemorrhoids’

poksyaa /poksja/ ‘tumor’

naaksyaa /naksja/ ‘small tumor’

gadaame jyaake /gɐɾdame dʒjake/ ‘a disease caused by mud or water into foot skin’

6.3.2.4 Nomenclature of Causative Agents of Illness and Disease

In science or philosophy every event have cause, such like illness and disease also have cause or causes. In medicine, some diseases are caused by microbes or parasites. Here, such words regarding microbes or parasites of Magars are presented as follows:

du /du/ ‘microbes, insects’

sul /sul/ ‘roundworm, worm’

phittyaa sul /pʰittyaa sul/ ‘tape worm’

churnatrichuria /tʃurna tritʃurja/ ‘pin worm’

sik /sik/ ‘head louse’

gheres /gʰeres/ ‘body louse’

dakaha /dɐkɐhɐ/ ‘tick’

lawat /lɐwɐt/ ‘common leach’

lin /lin/ ‘leech found in water’

jenghaa /dʒeŋʰa/ ‘mosquito’

burchhum /burʃʰum/ ‘flea’

6.3.2.5 Magar Words Related to Healings

Healing or treatment is a major part of medicine or health science. Here, some Magar words regarding to the healing and treatment are presented as follows:

usaahaa /usaha/ ‘medicine, drugs, treatment’

usaahaa jaatke /usaha dʒatke/ ‘treatment’

usaahaa kaaske /usaha kaske/ ‘to give medicine to take’

khop /k^hop/ ‘prevention, immunization’

khopke /k^hopke/ ‘to fencing or making barrier for disease’

archaa /ʌrʃa/ ‘needle’

sutke /sutke/ ‘to insert, to prick’

chhakkke /ʃ^hakke/ ‘to prick’

saato yatke /sato jatke/ ‘treatment of disease caused by fear’

6.3.2.6 Magar Words Related to Medicinal Plant (Herbs and Shrubs)

Traditionally, Magars were collect medicinal herbs& shrubs in their own season and stored to used when someone fall into ill. Some name of such medicinal plants in Magar language which were collected in field survey in study area is presented as follows:

thoksing /t^hoksiŋ/ ‘barro (Nep.)’

gwaangling /gwaŋliŋ/ ‘harro (Nep.)’

ghormet /g^hormet/ ‘amala (Nep.)’

gwasyaasing /gwʌsjaŋsiŋ/ ‘kukhure (Nep.)’

kaaphal /ka^hʌl/ ‘kaaphal (Nep.)’

pharedo /p^hʌredo/ ‘jaamunaa (Nep.)’

raini /rʌŋni/ ‘a kind of small trees which is used medicine’

jukryaak /dʒukrjak/ ‘a kind thorny small tree used in medicine’

thikan thyaap /t^hikʌn t^hjap/ ‘badalpate (Nep.)’

muruk /muruk/ ‘bhakkeulo (Nep.)’

pataksar /pʌtaksar/ ‘rhododendron’

hadam /hʌdam/ ‘asuro (Nep.)’

pati or khacha pati /pati, k^ha ʃpati/ ‘titepati (Nep.)’

gherena /g^herena/ ‘a kind of small plants used as medicines’

6.3.2.7 Words Related to Health and Public Health

Before introducing western medicine (allopathy), Magars were developed their own health care system. They had implemented rules and regulations to prevent disease. Such as if any epidemic disease spread (Desaan), they had to stop by marriage ceremony, feast and unnecessary travels and so on. They had their own sanitary system. For examples bathing ceremonies such like Maghe Sakarati, New-year ceremony and they also organized special days to make roads, decoration of houses and so on. In Magar language ‘*Reske*’ means

bathing or bathing head, 'Meske' means washing face, 'Hurke' means washing hands, body or cloths, 'Thutke' means brushing teeth and washing dishes; from these varieties of words helps to understand sanitation and public health in ancient civilization of Magars. Here some words of Magar language related to the health and public health obtained from field survey is presented as follows:

chhaake /tʰhake/ 'to become ill'

jhercha /dʒʰertʃʌ/ 'healthy'

gepcha /geptʃʌ/ 'healing'

desaan /desan/ 'epidemic'

usaahaa /usaha/ 'medicine, drugs, treatment'

mandaru /mʌndʌru/ 'patient, ill person'

chhaacha bharmi /tʰhʌtʃʌ bʰʌrmi/ 'ill person, patient'

laakke /lakke/ 'to smear'

sittke /sitke/ 'to broom or to make dry'

di haataakke /di hatakke/ 'to boil water'

6.3.2.8 Words Related to Faith Healings

Faith healing in the Magar society is found as medical pluralism and Magars are taking as an alternative medicine for better health. Some Magar words used in faith healing is presented as follows:

laamaa /lama/ 'shaman, faith healer doctor'

warcha bharmi /warʃʌ bʰʌrmi/ 'junior shaman, junior faith healer'

aakhat /akʰʌt/ 'small quantity of rice which is touched by ill person and see by shaman to diagnosed disease (Nep. Akshetaa/achhetaa)'

garaangke /gʌraŋke/ 'commitments to god, goddess or evils to do worship or perform puja for someone's better health'

soatke /soatke/ 'commitments to god, goddess or evils to do worship or perform puja for someone's better health'

masaan lohoke /mʌsan lohoke/ 'a kind of worship to heal someone caused by evil eyes Masan'

mhutke /mʰutke/ 'to blow air with chanting mantra'

begaar /begaar/ 'a kind of un-digestion illness caused by evil eye'

badaap /bʌdap/, **baraap** /bʌrap/ 'ash (used for mhutke)'

ghantu /g^hΔntu/ ‘a folk dance related to faith healing’

puja aaja /pudʒa adʒΔ/ ‘worship for healing’

ungyaa bhaakke /uŋja b^hakke/ ‘to separate soul’

chhyaapke /tʃjapke/ ‘spray (specially by ash or water by the lama or warcha bharmi)’

6.3.3 Conclusion

Magars have indigenous knowledge about the ill-health and medication which is in their own language, which are not stored in the knowledge bank. The local language and health care are related each other for effective health care service and targeted output. In medical sociology and medical anthropology indigenous knowledge about the ill-health and healing valuable for understand health care system and do intervention. Magars have their indigenous nomenclature of anatomy physiology of organs, illness, causation of illness and disease, medicinal herbs and shrubs, healing methods, indigenous knowledge about the health and healings, public health on their local setting and language. Some words have typical meanings which are difficult to translate other languages. However, these words related to ill health and medication are local indigenous knowledge protected from the community, which was creation of their ancestors.

Appendix-I: Questionnaire

Introduction of respondent

1. Name (optional) & Surname: 2. Age: 3. Sex: Male/Female
 4. Marital status: (a) Married (b) Unmarried (c) Single (d) Divorced 5. Age at Marriage.....
 6. Mother tongue 7. Other Language Known: 8. Education
 9. Religion: (a) traditional or animist (b) Buddhist (c) Kirant (d) Hindu (e) Christian (f) Muslim (g) Others...
 10. Occupation : 10.1 If, foreign employment, Name of country

Family situation of respondent

11. How many members are in your family including male and female?
 (a) Total family member.....persons (b) Female.....persons (c) Male persons
 12. Types of family: (a) Unitary (b) Joint
 13. How many members can speak mother tongue in your family?
 (a) Speaking mother tongue (b) Only understand (c) Can't understand
 14. Give your family member's description about age, educational status and age at marriage of married members.

Age status			Educational status			Age at first marriage				
Age	Number		Level of Education	Number		Age at marriage (in year)	Married before 10 Years		Married after 10 Years	
	F	M		F	M		Female	Male	Female	Male
Under 5 Yrs			Illiterate			Under 15 Yrs				
06 - 15			Literate/ Primary			16 - 18				
16 - 25			Lower secondary			19 - 20				
26 - 35			Secondary			21- 25				
36 - 45			Certificate/+2			26 - 30				
46 - 55			Bachelor & above			31 - 35				
56 - 65			Children having under-age to go school			36 - 40				
66 & above			School dropped-out children under 18 yrs			41 & above				

15. How many members are able and unable to earn/work in your family?
 (a) Able to work/earn = (b) School Students = (c) Old age members =
 (d) Handicapped = (e) Chronic Ill/Unable to work = (f) Under 5 Yrs children =

16. What are your family income sources ?

SN	Income source/Occupation/ Profession	Number	If income source is foreign employment, Country's Name

17. How much percentage or fraction of total income of your family do you have saved?
 (a) 3/5 Parts of total income (60%) (b) 2/5 parts of total income (40%) (c) 1/5 parts of total income (20%)
 (d) No saving (e) Other (specify)

Section -A
Situation of Health and Medication Among the Magars

SN	Questions	Answers
1	Do you have any illness yourself or any family member within your family before one year of the survey?	(a) Yes 01 (b) No 02
1.1	If yes, where did you went or took away to ill-person for treatment at first?	(a) Shaman (Lama/warcha bharmi).....01 (b) Govt. Health post/institution02 (c) Medicine Shop/Private Clinic03 (d) Hospital04 (e) Other
2	Before five years of the survey, how many times do you have gone or brought to government health institution/health post being illness any member of your family?	(a) Once 01 (b) 2-3 times 02 (c) Four or more times ... 03 (d) Haven't gone 04 (e) Don't know99
3	Before five years of the survey, how many times do you have gone in medicine shop/clinic, private/community hospital being illness any member of your family?	(a) Once 01 (b) 2-3 times 02 (c) Four or more times ... 03 (d) Haven't gone 04 (e) Don't know99
4	Before five years of the survey, how many times do you have gone or invited in your home to the local shaman (<i>lama/warcha bharmi</i>) for treatment/ prevent from spirit or illness/ to show or worship for affiliation spirit etc?	(a) Once 01 (b) 2-3 times 02 (c) Four or more times ... 03 (d) Haven't gone/invited..04 (e) Don't know99
5	Do you have wearing blessed charm (<i>Jantar</i>) by anybody in your family given by shaman/traditional healer to prevent illness and suffering, for better fortune (<i>Grahadasa</i>) ?	(a) Yes 01 (b) No 02
5.1	If yes, by whom?	(a) self 01 (b) son/Daughter02 (c) wife03 (d) Father/Mother04 (e) other.....
6	In your opinion, why people are wearing blessed charm (<i>Jantar i.e. made by paper written with mantra or using by herbal medicine</i>) given by traditional healer or shaman?	(a) Wishing to good health01 (b) To strengthening fortune ...02 (c) Satisfaction of mind03 (d) Being Traditional custom ...04 (e) Other
7	Did your ancestor (Father/Mother, Grand Father/Mother etc) teach to you medicinal plants and traditional medicine which were existed in your ethnic group?	(a) Sufficiently taught01 (b) A little bit taught02 (c) Haven't taught03
8	In your opinion, how much expensive is modern health and medical care at present?	(a) Cheap/Accessible.....01 (b) Affordable02 (c) Expensive03 (d) Very expensive04 (e) Don't Know99
9	Which is cheaper in between traditional healing (<i>e.g. lama, herauone charaune, worships, traditional dance for healing, herbs & shrub etc.</i>) and modern medications in your village?	(a) Traditional healing 01 (b) Modern medicine 02 (c) Both are expensive03 (d) Don't know99
10	Do you have store traditional medicines or medicinal herbs & shrubs which were known or used by your ancestor in your house?	(a) do store.....01 (b) before done but not now02 (c) Go to find out when necessary ..03 (d) Don't do store04 (e) Don't know99
11	Do you have store allopathic medicines in your house for simple illness (e.g. Headache, common cold, diarrhea, fever, Abdomen pain etc)?	(a) Frequently do store 01 (b) Sometime do store02 (c) Go to buy when needs03 (d) Don't do store04 (e) Don't know99

12	Do the health workers of NGO/INGOs come to in your house or village for providing health awareness and health education?	(a) Do come in household01 (b) Do come in the village02 (c) Do come sometimes03 (d) Don't come04 (e) Don't know99
13	Did you have seen anybody in your village are selling drugs or providing medical service at door to door?)	(a) Yes01 (b) No.....02
13.1	If yes, what types of merchants or health workers of the institutions do you have found?	(a) Herbal medicine seller01 (b) Health workers of institutions ...02 (c) <i>Jhole</i> Doctors03 (d) Others04
14	In your opinion, could you belief about medicinal herb & shrubs or traditional healing can heal the illness till now?	(a) Most of illness can be heal01 (b) Few illness can be heal02 (d) No belief95 (e) Don't Know99
15	In your opinion, do you belief about allopathic medicine can cure all types of diseases?	(a) Most of diseases can be cure....01 (b) Few diseases can be cure..... 02 (d) No belief95 (e) Don't Know99

Section - B

Concepts related to health and illness

SN	Questions	Answers
1	In your opinion, do you belief on your following God-spirit (e.g. God of lineage, Godlings, God Goddess, Bayu etc.) cause to ill when they anger with you or there is problem in either worshipping or remembrance?	(a) Very much01 (b) Somewhat.02 (c) No belief95 (d) Don't know99
2	In your opinion, do you have belief on evil-spirit (e.g. <i>Masan, ghost, Rakchhes, Kichakanni, Nidani, Witch</i> etc.) cause to ill by exorcise or by pierce or practice secretly?	(a) Very much01 (b) Somewhat.02 (c) No belief95 (d) Don't know99
3	In your opinion, do you have belief on God, Goddess or Godlings cause to ill when somebody urinate or defecate or do dirt surrounding their shrine place as like <i>god-thān or shrine?</i>	(a) Very much01 (b) Somewhat.02 (c) No belief95 (d) Don't know99
4	In your opinion, how much do you have belief on misfortune or bad luck in accordance to planet horoscope cause illness?	(a) Very much01 (b) Somewhat.02 (c) No belief95 (d) Don't know99
5	In your opinion, how much do you belief on there are witch/sorcerer (<i>Boksa/Boksi</i>), who cause to illness somebody via exorcise or pierce through cast spell to secret practice?	(a) Very much01 (b) Somewhat.02 (c) No belief95 (d) Don't know99
6	In your opinion, could we fall in to illness in imbalanced of daily food (e.g. over-eating, under-eating, unnecessary eating) which we had taken?	(a) Yes01 (b) No02 (c) Don't know99
7	Do you have knowledge about microscopic biotic (e.g. bacteria, virus, fungus etc) can infect to cause illness?	(a) Know96 (b) heard only97 (c) Don't know99
8	Do you have knowledge about side effects of allopathic medicine when it is used to cure illness?	(a) Know96 (b) heard only97 (c) Don't know99
9	Why people sprinkle alcohol (liquor) to clean or purify shrine of god goddess and Godlings before worship or offered to God Goddess & Godlings in Magar culture?	(a) To kill micro-organism/Insects ...01 (b) To banish evil spirit02 (c) To please god goddess/godlings ..03 (d) Traditional custom04 (e) Don't know99

10	What is the reason to maximum use of <i>Titepati (Patisar)</i> for doing worship or purifying rituals in Magar culture?	(a) Being medicinal/pure herb.....01 (b) Being smell to chase insects02 (c) Traditional custom03 (d) Others..... (e) Don't know99
11	Do you know about misusing allopathic medicines or taking medicine without doctor's recommendation by the pregnant women might cause to be harmed for the foetus.	a) Know96 (b) heard only97 (c) Don't know99
12	In your opinion, what kinds of health problem in pregnancy when pregnant mother suffering from high blood pressure, swelling of limbs or face, protein in urine, blurred vision and fainting symptoms ?	(a) General condition 01 (b) Condition of illness02 (c) Danger sign of pregnancy03 (d) Don't know99
13	In past time five years period before survey, did somebody give birth in your family?	(a) Yes 01 (b) No.....02
13.1	If yes, somebody has given birth; where did you go to do delivery at birth time?	(a) With in home01 (b) Local Govt. Health institution ...02 (c) Pharmacy/clinic03 (d) private/Non-Govt. hospital04 (e) Other
13.2	If birth was given within home, who helped her to delivery while giving birth at home?	(a) Mature females of family/Kinship .01 (b) Traditional birth attendance02 (c) Health volunteers03 (d) Inviting health worker04 (e) Self give birth05 (f) Others
14	Which utensil is better to cut the umbilical cord after the child birth when delivery at home.	(a) Whatever available.....01 (b) Clean sickle/small sickle knife.....02 (c) Clean blade, scissor03 (d) Sterilized blade, scissor.....04
15	After how many hours took a bath for the newly born baby in the Magar villages?	With inHours
16	How do you manage the umbilical cord after falling of the baby?	(a) Buried near hearth/oven01 (b) Kept safely02 (c) Thrown anywhere03 (d) Other (e) Don't know99
17	In your opinion, why <i>bhalayo, kurilo, siru</i> or plants with having thorn and poisons property to cause ill are burned to produce smoke and worshiped in the naming day (<i>Nwaran</i>) of child in the Magars?	(a) To prevent from the illness01 (b) To prevent from the those poisonous plants02 (c) Being traditional custom03 (d) Other (e) Don't know99
18	In your opinion, why peoples do give <i>tika</i> of ash or charcoal or turmeric etc. when they carry the child outside from home or do travel in evening for babies in the society?	(a) Prevent from evil-spirit01 (b) Wishing not become illness ...02 (c) Being traditional custom03 (d) Others (e) Don't Know99
19	Why people tie round by thread (<i>dhaja</i>) for <i>Bar, Pipal, Swami</i> trees or the <i>chaupari</i> or big trees and sprinkle by <i>achheta</i> , lies in the way when they carry their baby with them in the travelling?	(a) Prevent from evil-spirit01 (b) Wishing not become illness ..02 (c) Being traditional custom03 (d) Others (e) Don't Know99
20	In your opinion, what is the health related reason of cross-cousin (<i>mama cheli - phupu chela</i>) marriage among the Magars?	(a) Knowing health status of each other01 (b) To prevent communicable disease..02 (c) Only keep kinship relationship ...03 (d) Don't know99 (e) Others
21	Do you know about probability of hereditary defect or diseases (e.g. disability, mental retardation, sickle cell anemia etc) due to close kinship marriage (<i>mama cheli - phupu chela</i>)?	(a) Known96 (b) Heard only97 (c) Unknown99

22	On your opinion, why people are smear (<i>lipnu</i>) their house inner side to outer side when somebody dead and for death ritual in Magar custom?	(a) To throw out disease/illness.....01 (b) to maintain hygiene of house02 (c) To push out soul of deceased ...03 (d) Other (e) Don't know99
23	Do you have knowledge about nutritional sufficiency or under sufficiency by taking junk foods (e.g. instant noodle, Biscuit, potato chips, Cocacola, pepsi, redbull/ drinking foods etc) for the children?	(a) Known96 (b) Heard only97 (c) Unknown99
24	In your opinion, what is the cause of mental disease (e.g. Anxiety Neurosis, Depression, Psychosis etc.)?	(a) Being anger godlings/god spirit ...01 (b) Envy by the Ghost,Masan, Nidini etc. evil spirit02 (c) Difficiency of security and love from the family03 (d) Insecurity from the relative, society04 (e) Taking excessive thinking/anxiety 05 (f) Don't Know99

Concept related to Health Institutions

SN	Questions	Answers
25	Which type of governmental health institution is situated at your VDC?	(a) Sub- Health post01 (b) Health Post02 (c) Primary Health Center ...03 (d) Hospital04 (e) Don't Know99
26	How many types of medicines are freely distributed in your governmental health institution situated at your VDC according to governmental health policy?	(a) 22 - 25 types01 (b) 32 35 types02 (c) 40 types03 (d) Don't Know99
27	How many types of Vaccination against the diseases are provided by the governmental institution situated at your VDC?	(a) Against ten types of diseases01 (b) Against six types of diseases02 (c) Against four types of diseases....03 (d) Don't Know99
28	Do you have knowledge about post and training level of health workers who worked in governmental health institution situated at your VDC?	(a) Know96 (b) Don't know99
29	In your opinion, does the governmental health institution situated in your VDC is providing quality of health services for the people or not?	(a) Yes01 (b) No02 (c) Don't Know ...99
29.1	If No, why?	(a) Irregular presence of trained health worker in the institution01 (b) Due to not opening 24 hourly02 (c) Rude/irritating behavior of HW ...03 (d) Deficiency of medicines04 (e) Low quality of treatment05 (f) Being far distance 06 (g) Others (h) Don't know99
30	Do you understand clearly counseling language which is used by the health workers of the governmental institution in your VDC?	(a) Understand clearly01 (b) Understand partially02 (c) Difficult to understand03
31	How do you get doctor's or health worker's behavior toward you when you went governmental hospital taking someone patient or being illness yourself?	(a) Very helpful behavior01 (b) Generally helpful02 (c) Rude/Irritating behavior03 (d) Discriminating behavior04 (e) Insulting/Dominating05 (f) Other (g) Don't Know99

Section - C
Changes in concept of Health, illness and Medication practice

SN	Questions	Answers		
		Answers	Before 10yrs	After 10yrs
1	How do you drink water in your house?	(a) As like fetched/Nothing ...01 (b) Using filter02 (c) Using chlorine/Medicine ...03 (d) By boiling04 (e) Other.....		
2	What things do you used to wash your hands before eat food?	(a) Wash with water only01 (b) Wash with water and ash02 (c) Wash with water and soap ...03 (d) Don't Know99		
3	What things do you used to wash your hand after using toilet or defecation/urination?	(a) Wash with water only01 (b) Wash with water and ash02 (c) Wash with water and soap ...03 (d) Don't Know99		
4	Do you wash your limbs after working in field or working something before to enter Kitchen?	(a) Don't wash in hurry01 (b) Occasionally washing..02 (c) always washing03 (d) Don't know99		
5	Do you have made toilet in your house?	(a) Yes01 (b) No02		
5.1	If Yes, which types of toilet do you have?	(a) Dug well/pit latrine01 (b) Dug well/pit latrine with slab..02 (c) Water sealed latrine with raw wall03 (d) Modern latrine04 (e) Other		
5.2	If there is a latrine/toilet, do you have used or not?	(a) Regularly used.....01 (b) Mostly used02 (c) sometime used03 (d) Difficulty due to water problem04 (e) Don't use.....05		
6	Where do you do defecation or urination when you go away from house or farm work?	(a) Jungle/ravine, rivulet01 (b) Ask to neighbor latrine02 (c) Returned home for latrine ...03 (d) Others		
7	What types of hearth or oven do you have in your house?	(a) Traditional firewood01 (b) Improved firewood oven02 (c) Bio-gas plant oven.....03 (d) Tradition & Gas04 (e) Traditional & Bio-gas05 (f) Other		
8	In Which condition do you have go to modern health institution or doctor for treatment when you or family member fall ill?	(a) Not cure by worshipping /promise to worship01 (b) Not cure by shaman (Lama) ...02 (c) Instantly when fall in ill03 (d) In emergency condition04 (f) In serious/chronic illness05 (g) Other		
9	In which condition, do you have go to traditional healers/faith healer for treatment when you or family member fall ill?	(a) Instantly when fall in ill01 (b) In minor illness also02 (c) Not curing by doctor or Hospital's treatment03 (d) Suffering from chronic illness04		

SN	Questions	Answers		
		Answers	Before 10yrs	After 10yrs
		(e) When modern treatment became expensive05 (f) Other (g) Don't Know99		
10	How many medicinal herbs and shrubs do you have known which were used by your ancestors?	(a) A lots of01 (b) Only 5-7 types02 (c) Only 2-4 types03 (d) Could not recognize04		
11	How frequently do you take traditional foods (eg millet, maize, buckwheat, Arum leaf, nettle, <i>dhindo</i> , <i>anto</i> etc. dishes) in your family?	(a) Regularly01 (b) Mostly02 (c) Sometimes03 (d) Not taken04 (e) Don't know99		
12	Do you feed junk foods (eg. Instant noodles, biscuits, chocolate, cocacola, pesi, redbull, drinking beverage, potato chips etc packed foods) to your family?	(a) Mostly01 (b) Sometimes02 (c) Least03 (d) Don't know99		

SN	Questions	Answers		
		Answers	Before 5yrs	After 5yrs
13	Do you know the differences between communicable disease and non-communicable disease?	(a) Know96 (b) Heard only97 (c) Don't know99		
14	Do you know about family planning methods?	(a) Know96 (b) Heard only97 (c) Don't know99		
15	Do you have known about termination of unwanted pregnancy from the registered doctor or health institution in respect of reproductive right of female from the Nepal government?	(a) Know96 (b) Heard only97 (c) Don't know99		
16	In your opinion, how many times should be go to see doctor or health institution in pregnancy for pregnancy check-up?	(a) At least four times01 (b) At least three times02 (c) At least two times03 (d) As need/necessary.....04 (e) Don't Know99		
17	Do you have knowledge about Bird flue, Swine flue etc. which is transmitted from the bird and animals?	(a) Know96 (b) Heard only97 (c) Don't know99		
18	Do you know about Cancer disease?	(a) Know96 (b) Heard only97 (c) Don't know99		
19	Do you know about hypertension (high blood pressure) and heart diseases?	(a) Know96 (b) Heard only97 (c) Don't know99		
20	Do you know about Diabetes mellitus?	(a) Know96 (b) Heard only97 (c) Don't know99		
21	Do you know about chronic kidney failure disease (CKD)?	(a) Know96 (b) Heard only97 (c) Don't know99		

SN	Questions	Answers		
		Answers	Before 5yrs	After 5yrs
22	Why hypertension, diabetes mellitus, chronic kidney failure, cancer etc are increasing in the society in present?	(a) Modern food habit01 (b) Sedentary life style.....02 (c) Careless in food taking habit03 (d) Misuse of modern medicines04 (e) Taking lots of tension/thinking05 (f) Don't know99 (h) Others.....		
23	Do you know about communicable disease HIV/AIDS?	(a) Know96 (b) Don't know99		
23.1	If known, how HIV/AIDS transmitted from one person to another?	(a) Shaking hand01 (b) Sharing leftover food each other02 (c) Unsafe sexual intercourse03 (d) Via unsafe sex, blood, injections04 (e) Don't know99 (f) Others		
24	If there are children in your family, do you have vaccinate them which are provided from the government health institution?	(a) No small children01 (b) Vaccine given02 (c) Not Vaccinate03 (d) Don't Know.....99		
25	Do you have taken your-self or administered medicine to cure illness for family member without consulting doctor or health worker by buying or asking from the neighbour when fall ill in your family?	(a) Yes01 (b) No02		
25.1	If yes, which types of medicines are taken yourself or administered for family members?	(a) Over the counter drugs01 (b) Drugs related with common illness02 (c) Remainder drugs of patient for similar illness ...03 (d) Drugs which have little bit knowledge.....04 (e) Others.....		
26	Do you have knowledge about right of health and treatment is a fundamental right which is mentioned in constitution of Nepal?	(a) Know96 (b) Heard only97 (c) Don't know99		

Section -D

SN	Questions	Answers		
		Agree/ Right	Uncertain/ Don't know	Disagree/ Wrong
1	Illness is caused by pierce of evil spirit (<i>Ghost, Masan, Pichas</i> etc.).	1	2	3
2	Illness is cause by when god-spirit are anger with you in not doing worship them properly and timely.	1	2	3
3	Premature death person's soul could be ghost or pichas and they can cause to illness for humans.	1	2	3
4	Bad moral, conduct, manner or behavior of person could be caused of illness.	1	2	3
5	Microscopic bacteria, virus, protozoa and worms etc are causative organism of illness.	1	2	3
6	When evil eye saw you are eating something and envying can cuase to cursed (<i>Begar</i>) then to ill.	1	2	3
7	Misuse of alcohol containing beverage drinking could be cause to disease.	1	2	3
8	Cigarette and tobacco are harmful to the health.	1	2	3
9	Our traditional foods (<i>e.g. dhindo, anto, bread, arum leaf, nettle</i> etc.) are more nutritious than today's junk food.	1	2	3

SN	Questions	Answers		
		Agree/ Right	Uncertain/ Don't know	Disagree/ Wrong
10	Today's prevailing junk foods (e.g. <i>instant noodle, pepsi, soft drinks like cocacola, pepsi, potato chips</i> etc. packed foods) are not fully beneficial for good health.	1	2	3
11	Gastrointestinal infections and diseases are reduced when taking boiling water for drinking.	1	2	3
12	Local illness (e.g. <i>beggar, ganogola, kufat, sul, lagobhago</i> etc) can be identify or diagnose better by the shamans/traditional healers (lama) than the doctor.	1	2	3
13	Traditional healer shamans (Lama) are able to cure common local illness or specific local illness.	1	2	3
14	Worshiping God Goddess or Godlings or ancestor could be prevented from the illness.	1	2	3
15	Offering to worship for God Goddess or Godling, ancestor god which are worshiping form the traditionally could be reduce the illness when suffering from the illness.	1	2	3
16	Correctly use of medicinal herbs and shrubs which were used by the Magar ancestors can cure the diseases.	1	2	3
17	It is better to go health post, hospital or doctor clinic when suffering from the illness or disease.	1	2	3
18	Medicine can be administered without doctor or health worker's prescription could be harmful.	1	2	3
19	Peoples who have gone to India or foreign country, can be returned by importing communicable diseases.	1	2	3
20	Communicable disease can be transmitted one to another people which are fetched by who were returned from India or foreign country.	1	2	3
21	Bleeding, abdomen pain, swelling body, fainting etc complication occur in pregnancy should go hospital immediately.	1	2	3
22	Hospital delivery is better than home delivery for giving child birth.	1	2	3
23	To prevent from the diseases for infants should be vaccinated properly.	1	2	3
24	Carefully use of instruments, taking precaution in working could be reduce or prevent from injury.	1	2	3
25	People suffering from psychosis or mental illness are curable.	1	2	3
26	Family, relative and social support, assurance and love are essential to people who are suffering from mental illness.	1	2	3

Thank you for participation!

Notes:

Appendix-II: Questions for Key informants and Focus Group Discussion (for Qualitative Data)

A. General Introduction to the respondent

Full Name (optional)..... Age Sex

Marital Status Age at Marriage (if Married) Religion

Occupation Working Place Education

Mother Tongue Language Known Address:

Number of Family Member Types of Family

B. Health care and Medication Practice

1. Tell me about Magar's traditional culture and how is it shifted in present?
2. What types of god and goddess are worshiped in your locality?
3. What is the role of god and goddess in aspects of ill-health and healing?
4. What are the myths related to culture and Health?
5. What are the traditional social institution and organization of Magars?
6. How traditional social institution and organization are functioned in healing system?
7. Who are traditional healers in the Magar society?
8. How traditional healers heal the illness?
9. What were the traditional health care and Medication practice in the Magars?
10. What is the situation of Modern health care facilities within Magars ?
11. How many types healing system and health providers (medical pluralism) are found in the Locality?
12. What is the trend to receive the health care facilities traditional vs modern?
13. How costly are Modern health care, traditional healing care and other health care system?
14. Do you know any local name of disease?
15. Do you have any knowledge herb and shrubs which were used by Magar ancestors?
15. Are you satisfied from the traditional healing system?
16. Are you satisfied from government health care service provided in your area?

C. Socio-cultural perceptions towards health and illness

1. How Magars understand ill health and Medication?
- Mental health - physical health - social health
2. What are the socio-cultural reasons to fall in the illness?
3. What concepts of health & illness are found in the following Magar ritual and culture and how functioned existence ?

Feast & festivals, ceremony or Jatra	Cultural Values to function	Concepts of Health & illness
Baisakhe Sakranti Buddha Purnima Chandi Puja		
Dasahara		
Saune Sakranti Bhume/ Harelo puja		
Tij		
Dasai Tihar		
Pandhra Push Maghe Sakranti Shreepanchami		
Holi Chaite Dasai		
Other		
Rituals Birth Chhaiti Naming		

Bhatkhuwai Chhewar Marriage/Dhogbhet Chaurasi Puja Death		
<u>Worships of God & Goddess</u> Baji Bajai Puja Bayu puja Sansari Mai Puja Devi Deurali Puja Wanghe Puja Bhuyar Puja Kul Puja Bhumi puja Jhankri puja Ghar Paicho Ghantu Other		
Witchcraft/Ghost/ Rakchhes Spiritual Beliefs Sanitation on Than Nutrition Environment change and Health		
Others		

D. Changing in ill health Concept and Medication practice

1. What are changes in original Magar culture?
2. What are changes in original Magar Rituals?
3. Why original and traditional Magar culture and rituals are changing?
4. What are the changes in traditional Magar institution and organizations?
5. Why traditional Magar institution and organizations are changing?
6. How traditional healing systems are going to change today?
7. Why traditional healing systems are going to change?
8. What are the changes in concept of ill-health?
9. Why are going to leave to worship your traditional god and goddess?
10. Why Magars are forgetting medicinal herbs and shrubs which were used by ancient Magars?
11. What is the changes in sanitation and drinking water in your community?
12. What is affecting foreign employment in regarding Mental and physical health of the Magars?
13. Why new communicable disease are appearing in your community
14. Why Cancer, Hypertension and Heart Disease, Kidney failure, Diabetes etc non-communicable disease are increasing?

Thank you for participation!

Appendix-III: Check List for field visit

A. Social Organizations

1. Family and Kinships
2. Economic Activities & Health
3. Customary institutions
4. Modern institutions

B. Infrastructure of study area

1. Health facilities
2. Drinking water facilities
3. General sanitation
4. Educational facilities
5. Development of road and other infrastructures

C. Culture & Health, Illness and Medications

1. Life cycle ceremony
 - a. Birth
 - b. Marriage
 - c. Death
2. Feasts and festivals
3. Worship/Gods and Goddess
4. Fashions and food habits
5. Situation of Male and Female
6. Traditional health Care system
7. Uses of herbs & shrubs in illness.

D. Socio-Cultural Concepts in Health and Illness

1. Causes to make illness
2. Tradition healers
3. Healing Methods
4. Belief of people

E. Miscellaneous

1. Study Process
2. Physical responses and their expression of respondents
3. Interrelationship between the respondents and with researcher
4. Phenomenological experiences of respondents

Appendix-IV: List of Key Informants

SN	Name	Age	Sex	Address	Interview Date	Remarks
1	Kansi Ram Rana	74	M	Alamdevi-5 Lasarghabesi	18/12/2071 BS	Ex-British Gurkha Army/ Senior citizen
2	Bhuwan Sing Rana	51	M	Alamdevi-3, lasarghabeshi	18/12/2071	Headmaster, Adarsha Primary School
3	Jayanti Rana	59	F	Alamdevi-5, Lasarghabesi	18/12/2071	Social worker
4	Man Bahadur Thapa	76	M	Alamdevi -5	19/12/2071	Senior Citizen
5	Rimisara Rana	41	F	Alamdevi-4	19/12/2071	Teacher
6	Nar Bahadur Rana	52	M	Alamdevei -5	19/12/2071	VDC President (immediate past)
7	Til Sara Thapa (Palli Magar)	65	F	Alamdevi-5, Dhemthok	20/12/2071	Social worker, Senior citizen
8	Bir Bahadur Ale	74	M	Alamdevi-1, Kotakot, Besi	21/12/2071	Ex- Indian Gurkhas/ Senior citizen
9	Ek Bahadur Ale	67	M	Alamdevi-1, Kotakot,	21/12/2071	Ex- Indian Gurkhas (Subedar)/ Senior citizen
10	Kansiram Thapa	75	M	Chandibhanjyang- 1, Ghurdanda	22/12/2071	Senior Citizen/ Ex- Indian Gurkha Army
11	Indra Bahadur JhendiMagar	50	M	Chandibhanjyang- 1, Ghurdanda	22/12/2071	Teacher
12	Khagi Gaha	86	F	Chandibhanjyang- 1, Ghurdanda	22/12/2071	Senior Citizen
13	Tek Bahadur Resmi	61		Chandibhanjyang- 2, Tungkot	22/12/2071	Senior Citizen
14	Krsishna Bdr Lamichhane	40	M	Chandibhanjyang- 2, Lihunk	22/12/2071	VDC chairman (immediate past)
15	Rudra Bahdur MaskiRana	56	M	Chandi Bhanjyang-3, Khalhuwa	23/12/2071	Local Shaman
16	Om Bahadur Gaha	77	M	Chandibhanjyang- 2, lihuk	23/12/2071	Local Shaman
17	Chandrakala Rana	87	F	Birgha-01, Gokurhunggha	24/12/2071	Senior Citizen
18	Til Bikram Rana	80	M	Birgha- 07, Bhustung	24/12/2071	Senior Citizen
19	Khum Bahadur Gaha	65	M	Birgha-07, waigha	24/12/2071	Senior Citizen
20	Pritha Rana	55	M	Birghar-06, kharsunggaira	25/12/2071	Teacher
21	Rishisor Rana	91	M	Birgha-03,	25/12/2071	Senior Citizen

				Kaindanda		
22	Narayan Sing Gaha	60	M	Birgha- 08 waigha	25/12/2071	Senior Citizen
23	Inisara Gaha	84	F	Birgha-08, waigha	25/12/2071	Senior Citizen
24	Gopi Ram UchaiMagar	75	M	Malhungga-4, Bojhadi	04/01/2072	Senior Citizen
25	Dil Bahadur Saru	97	M	Malhungnga-4 Bojhadi	04/01/2072	Senior Citizen
26	Gaj Bahadur Hiski	49	M	Malhungga-04, Bojhadi		Local primary School Teacher
27	Indra Bahadur Thapa	89	M	ShreeKrishna Gandaki-01, Balam Jaipate	06/01/2072	The Magar Jaisi
28	Wum Maya Thapa	43	F	ShreeKrishna Gandaki-01, Balam	06/01/2072	Local Teacher
29	Mohan Sing Saru	58	M	ShreeKrisna Gandaki -5, Imsil	07/01/2072	Social worker
30	Chandra Bahadur Saru	88	M	ShreeKrisna Gandaki -5, Imsil	07/01/2072	Senior Citizen
31	Sun Maya Somai	66	F	ShreeKrisna Gandaki -5, Imsil	07/01/2072	Senior Citizen
32	Khim Bdr Thapa	43	M	ShreeKrisna Gandaki -5, Imsil	07/01/2072	Social worker
33	Jhaman Sing Thapa (Somai)	79	F	ShreeKrisna Gandaki -2, Balamdanda	07/01/2072	Senior Citizen
34	Sursing Thapa	71	M	Jagatradevi-6, Pakhrek	09/01/2072	Subedar, Ex-Indian Army/ Senior Citizen
35	Bhim Maya Hiski Rana	57	F	Jagatradevi-6, Garangdi	09/01/2072	Woman health volunteer
36	Amrita Hitan Shrestha	61	F	Jagatradevi-5, Garangdi	09/01/2072	Social worker
37	Padam Bahadur Thapa	79	M	Jagatradevi-5, Garangdi	09/01/2072	Senior Citizen
38	Aibar Thapa	67	M	Jagatradevi-4, Garangdi	10/01/2072	Senior Citizen
39	Rim Bahadur Thapa	62	M	Jagatradevi-4, Garangdi	10/01/2072	Ex Army Captain
40	Bahadur Sing Rana	66	M	Jagatradevi-4, Garangdi	10/01/2072	Senior Citizen
41	Man Bahadur Rana	42	M	Jagatradevi-6, Khusilo	10/01/2072	Social worker, Shopkeeper
42	Sher Bahadur Rana	45	M	Pelakot- 2, Kalleri	20/01/2072	Social Worker
43	Tikalal Rana	65	M	Pelakot- 2, Kalleri	20/01/2072	Ex-Gurkha Army

44	Nar Bahadur Darlami	56	M	Pelakot- 2, Kalleri	21/01/2072	Local Shaman
45	Dal Bahadur Rana	50	M	Pelakot- 2, Kalleri	21/01/2072	School Teacher
46	Sarbajit Gaha	57	M	Pelako-1, Ramche	23/01/2072	School teacher/ Host of Ghantu Dance
47	Bhakta Bahadur Rana	70	M	Pindikhola -4, Bharakha	21/01/2072	Senior citizenship
48	Bhim Bahadur Phungjali	66	M	Pindikhola-4, Dyangthung	21/01/2072	Umaraa of the Bhalthum-Kot
49	Gupta Bahadur Thapa	62	M	Pidikhola-4, Lapsidanda	21/01/2072	Ex-Gurkha Army/ social worker
50	Bhim Bahadur Thapa (Taram)	50	M	Pindikhola-9, Kolhdanda Syalbas	22/01/2072	School Teacher
51	Khagi Sara Gaha Thapa	55	F	Pindikhola-5, Patikharka	22/01/2072	Shaman/ Mata
52	Dil Bahadur Siras Thapa	45	M	Nibuwakharka-3, Rupakhani	25/01/2072	Social worker
53	Khadka Bahadur Hitan Thapa	88	M	Nibuwakharka-3, Rupakhani	25/01/2072	Senior Citizen
54	Tika Ram Thapa	70	M	Nibuwakhar-4, Gijandanda	26/01/2072	Ex-Gurkha Army/ Senior Citizen
55	Lal Bahadur Thapa	51	M	Nibuwakharka-4, Muti	26/01/2072	Social Worker

Appendix-V: Glossary

Achhetā	Sacred rice grain, which is offered to the god and goddess or committed to worshiped respected god and goddess to get relief from trouble, misfortune or illness
Aakhat/ākhat	A cup (mānā) full of rice which is touched by the ill person fingers and lāmā or wārcha bharmi (traditional healer, shaman) looks the rice to diagnose the illness or causative spirits of illness. Actually it is also fee of the traditional healers.
Angdi/āngdi	The <i>Andhikola River</i> of syangja district, which ended in Kaligandaki river surrounding tamkikot hill of district. The meaning of āngdi world in Magar language is water generated from the body (āng- body, di-water) and another meaning is a kind of fear creating condition (āngke) due to river or wide river bank.
Bāyu	An ancestral god or goddess of a family or <i>bhāikhalak</i> ; which is spirit of died person whose soul had not reached in <i>boikunghau</i> (heaven) and roaming in the earth
Bhāikhalak	Brotherhoods of same clan from the patriarchal side and who has becomes common ancestor before few generations ago. And they fall into ritually impure for worship in birth and death of someone within the clan
Bhakkal/bhākal	A commitment to god, goddess or spirits in doing worship in near future when someone falls into illness, misfortune or troubles
Bhejā	A kind of co-operative and traditional institution, which was broadly practiced among the Magars in past, but, today such systems are disappeared due to changes in political and governmental administration system. Nowadays only remainder of bheja, is seen in worship ceremony such as chandi bheja, maipuja bheja etc. and villagers collect assistance for that worships within the villages.
Bhoto	A traditional dress; wear by the male, which is used instead of shirt and stitched without keeping modern button
Bhut prēt	Local name of ghost and evil spirit which can cause illness to the peoples
Chandi	A god of cloud, thunder and rain worshiped on Chaitra to Baisakh month (specially, in full moon of the Baisakh month) and assumed fortune of raining and climate change in worshipping ritual.
Charhaitke	Food or something offering to god, goddess or spirits/souls
Chaupāri	A traditional rest place in the path, where plants such like Bar, Pipal, Swami or other trees who gives cool wind, shade
Choli/chola	A traditional dress; wear by the female which is stitched without modern button and it covered the chest and back.
Chhācha Bharmi	Ill -person, patient
Devi Dhyākke	Offering goddess and ritually worshipping for goddess (Bandhan)

Gado/Bhangra	A traditional dress; a piece of clothe which is wear in the backside (trunk) and useful for herding, and other agricultural works
Garāngke	Committing to worship for god with offering achheta or chicken rounding just upside head of ill-person from right to left side (3 or more odd times) and gwa or achheta garangke worship is compulsory done in the as per ritual date.
Ghantu	A traditional lyrical drama based story of three kings and queens assuming god and goddess which is performed for faith healings when someone falls illness within the family or kin.
Ghalek	A traditional dress; wear by female, it covers the chest to back and made from the one piece of cloth
Ghorpyak	A traditional ornament made from wood; and used also keep sickle
Godlings	local god and goddess
Grahadashā	Belief on luck or bad luck (fortune/misfortune) according to planet movement horoscope or astrology, generally tells by priests and astrologers in the community.
Gunyu	A traditional dress; wear by female, which covers the waist to leg. In waist tied with Matha (patuka).
Jantar	The shaman or astrologer or priest write sacred Mantra, blessed with mantra and fold it and packed in some metal or waterproof material and wear at neck (as like ornament) or other part or body, blessed charm and there became belief that it protect from the illness
Kachhad	A traditional dress; wear by the male, which is one piece of cloth and covered to waist to knee
Kuldewatā	The clan god and that god is believed that common ancestor of respected clan. Different clans have different clan gods among the Magars and different ritual to worship and date too.
Kutumba	Husband of sister or daughters and they assist to complete life cycle ritual, worships and other ritual tasks,
Ledhini/nidhini	A female jungle shaman (Banjhakri) or a kind of spirit which brought somebody person into cage (odār) and cause to illness
Lāgobhāgo	The illness caused through perching by the evil spirit, sorcery or illness caused by the spirits of god and goddess, evil spirits
Lāhuryā	Those persons who goes to foreign countries including India to earn money for subsistence of family livelihood. In past, the soldiers of Gurkha regiments of British and India were only called lāhuryā. But, nowadays that definition has been changed and covers broader sense of working in foreign country.
Lāmā/lama	A shaman or philosopher of the Magar society and healer of the community.
Lām/lam	The way, path or road
Masan/masān	A kind of soul of death person and evil spirit which can cause illness to the peoples

Matha (patuka)	A kind piece of cloth which is used as like belt for gunyu, gonya
Mos	Indigenous nomenclature of an illness where diarrhea occurs for infants and the infants suffer from green and watery diarrhea
Moch	Indigenous nomenclature of an illness and the illness is having frequently abortion and leading to infertility or infant death after birth frequently
Nātle	Holiday in agricultural work in festivals or full moon and black moon days
Rakchhes	A kind of ghost and evil spirit which can cause illness regarding heart like such like myocardial-infraction and some time ill-person could be died due to eating heart by the rakchhes.
Rodi	A kind of social institution where youths gathered and do entertainments through singing and dancing; but nowadays such culture is going to disappears
Than/thān	A habitat of god or goddess. Generally, Magars erects two flat stone and beamed by another flat stone, then they construct idol of god or goddess from mud or cow dung or flour of sometime stone, smeared the place and kept titepāti and worshiped ritually.
Tikā	Putting a mark in forehead with yoghurt and rice or other things as in ritual or culture or religious ceremony
Usāhā	medicine or drugs for treatment, substances for treatment or cure, treatment
Umarā	Priest of kot (fort) and head of the fort; the <i>umarā</i> conducts the sacrificing worship at Kot in dashain festivals, <i>panchawali</i> worships etc and <i>Umarā</i> becomes certain clans of Magars among the village
Wāpā	The local Magar priest, based on Buddhist philosophy. The <i>wāpā</i> were constructed due to movement of Magar identity and against exploitation in named of Hindu caste hierarchy and Brahmin priest. The meaning of <i>wāpā</i> in Magars language was kept as <i>wārchā pāhācha</i> bharmi (Having knowledge, educated person).
Wārchā bharmi	A person who knows little bit shamanism or healing or ritual offerings and able to healing minor illness